Pfizer COVID-19 Vaccine (12 years and over)

INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: / /	Age:
ADDRESS		EMAIL	
CITY	STATE / ZIP	DAYTIME PHONE NUMBER	
EMERGENCY CONTACT: Name	Relation	Phone Number	

Race: (check only 1)	Ethnicity: (check only 1)	Primary Language:	Gender:
☐Asian/Polynesian ☐Black ☐Multiracial ☐Native Am/Alaskan ☐White ☐Unknown	☐ Not Hispanic ☐ Hispanic ☐Unknown	☐ English ☐Other _____	☐Male ☐ Female

Vaccine	State Eligible code (GIP)	Site	VIS(Mo/date/Yr)	Procedure code
Pfizer-COVID-19	COVP	IM	11/2021	91300

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: ☐ Pfizer ☐ Moderna ☐Janssen ☐ Other: _____			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Check all that apply to you: ☐Have a history of myocarditis or pericarditis ☐Have a history of Guillain-Barre Syndrome ☐Have a bleeding disorder or take blood thinners ☐Have a history of heparin-induced thrombocytopenia (HIT) ☐Am currently pregnant or breastfeeding ☐Have received dermal fillers ☐Had COVID-19 and was treated with monoclonal antibodies or convalescent serum ☐Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection			
5. Check all that apply to you: ☐ Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____ ☐ Take immunosuppressive drugs or therapies: If yes, please list: _____			

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following): Pfizer (age 12 & over). I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.

My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.
Those with previous anaphylactic reactions should stay for 30 minutes

_____ **Date** _____ **Print Name** **X**_____ **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient provided:
☐ **Pfizer (age 12 and over)** https://labeling.pfizer.com/ShowLabeling.aspx?id=14472&format=pdf

Payment Method:
☐ Medicare (Part B)
☐ Private Insurance
☐ Medicaid/CMO
☐ No Insurance

Member Number _____ Group Number _____

Are you the primary card holder?
☐ Yes (Stop here)
☐ No (complete section)

Name of insurance/HMO _____

Primary card holder name _____

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot #	Expiration Date	Name of Vaccine Administrator/Provider #
Pfizer (12 years and older)	_____ml ☐ 1st _____ml ☐ 2nd _____ml ☐ 3rd _____ml ☐ 4th _____ml ☐ 5th	☐ IM - L Arm ☐ IM - R Arm ☐ IM - L Leg ☐ IM - R Leg				Use by Date	