



Pfizer COVID-19 Vaccine (Age 5-11)
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) <input type="checkbox"/> Asian/Polynesian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Am/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Unknown		Ethnicity: (check only 1) <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Vaccine	State Eligible code (GIP)	Site	VIS(Mo/Yr)	Procedure code	
Pfizer-COVID-19	COVZ	IM	10/2021	91307	

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: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> 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: <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Have a history of Guillain-Barre Syndrome <input type="checkbox"/> Have a bleeding disorder or take blood thinners <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection			
5. Check all that apply to you: <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____ <input type="checkbox"/> 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 5 through 11) 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

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

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient provided:
 Pfizer (age 5 through 11) <https://www.fda.gov/media/153717/download>

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

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

Member Number _____ Group Number _____ Name of insurance/HMO _____ Primary card holder name _____

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot #	Expiration Date	Name of Vaccine Administrator/Provider #
Pfizer (Age 5 – 11)	_____ ml <input type="checkbox"/> 1 st	<input type="checkbox"/> IM - L Arm <input type="checkbox"/> IM - R Arm <input type="checkbox"/> IM - L Leg <input type="checkbox"/> IM - R Leg					
	_____ ml <input type="checkbox"/> 2 nd						
	_____ ml <input type="checkbox"/> 3 rd						
	_____ ml <input type="checkbox"/> 4 th						
	_____ ml <input type="checkbox"/> 5 th						
						Use by Date	