Northeast Health District: Pfizer COVID-19 Vaccination Consent Form

Section 1: Information about Patient to Receive COVID-19 Vaccine

PATIENT NAME (Last) If applicable, Suffix	(First)	(M.I.)	PATIENT'S MAIDEN NAME	COUNTY OF RESIDENCE
PATIENT BIRTHDATE (mm/dd/yyyy)	PATIENT AGE	GENDER ☐ Male ☐ Female ☐ Transgender	Mother's Maiden Last Name	
ETHNICITY ☐ Not Hispanic/Latino ☐ Hispanic Latino	RACE ☐ Asian ☐ Black ☐ White ☐ Native American/Alaska Native ☐ Native Hawaiian/Other Pacific Islander		MARITAL STATUS ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
MAILING ADDRESS			PHONE NUMBER	
CITY STATE		ZIP CODE	E-MAIL	
EMERGENCY CONTACT PERSON NAME	RELATIONSHIP		PHONE NUMBER FOR EMERGENCY CONTACT PERSON	

Section 2: Medical Information: *The following questions will help us to determine if this person can receive the COVID-19 vaccine.*

1.	Is the person to be vaccinated feeling sick today?	☐ Yes	☐ No
2.	Has the person to be vaccinated ever received a dose of the COVID-19 vaccine?	☐ Yes	☐ No
3.	Has the person to be vaccinated ever had an allergic reaction to: a component of the COVID-19 vaccine (polyethylene glycol, or polysorbate) or a previous dose of the COVID-19 vaccine?	☐ Yes	☐ No
4.	Has the person to be vaccinated ever had an allergic reaction to another vaccine or an injectable medication?	☐ Yes	☐ No
5.	Has the person to be vaccinated ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, or any vaccine or injectable medication? This would include pet, food, environmental, or oral medications.	☐ Yes	☐ No
6.	Did the person to be vaccinated received any vaccine in the last 14 days?	☐ Yes	☐ No
7.	Has the person to be vaccinated ever had a positive test for COIVD-19 or has a doctor ever stated that they have COVID-19?	☐ Yes	☐ No
8.	Has the person to be vaccinated ever received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes	☐ No
9.	Does the person to be vaccinated have a weakened immune system, have a history of cancer, or take immunosuppressive drugs or therapies?	☐ Yes	☐ No
10.	Does the person to be vaccinated have a bleeding disorder or is taking a blood thinner medication?	☐ Yes	☐ No
11.	Does the person to be vaccinated have a history of or a risk factor for a blood clotting disorder?	☐ Yes	☐ No
12.	Is the person to be vaccinated pregnant or breastfeeding?	☐ Yes	☐ No
13.	Does the person to be vaccinated have dermal fillers?	☐ Yes	☐ No

Section 3: CONSENT: *If this consent form is not filled in completely, signed and dated, the patient will not be vaccinated.*

I GIVE CONSENT to DPH District 10 for the patient named above to receive the COVID-19 vaccine. I acknowledge that the patient and medical information provided above is correct. I have been given a copy of and have read (or have had explained to me) the information in the Emergency Use Authorization COVID-19 Fact Sheet for Recipients and Caregivers. I have been given an opportunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and request it be given to me or to the patient named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 15 minutes at the clinical site after receiving the immunization in case of a reaction to the vaccine.

***Patient/Guardian Signature:*________________________________ *Relationship:*_______________ *Date:*_________**

HN2 Code	Vaccine Description	Source	Age Range Dosage/Route	Manufacturer Trade Name	NDC	Lot #	Site / Route
mRNA; LNP-S	Pfizer-BioNTech COVID-19 Vaccine	StSupl	> = 12 years 0.3 mL	Pfizer-BioNTech COVID-19 Vaccine	59267-1000-02		LD RD LVL RVL Intramuscular

Revised 5/11/21 WRH Signature of Provider ____________________________________Date:_________________