COVID-19 Vaccine CONSENT Form-PFIZER

Please complete all information listed below.

Name: (Print) _____Date of Birth: _____

Address: _____City:_____State:_____Zip:_____

Phone #:_____Primary Care Provider: _____

Insurance: _____ Policy #:_____

Gender: _____Race: _____Ethnicity: _____

☐ **Yes or** ☐ **No** Are you 18 years old or over?

☐ **Yes or** ☐ **No** Do you have a history of severe allergic reactions (requiring epinephrine or resulting in hospitalization) after receiving a vaccine or other injectable?

☐ **Yes or** ☐ **No** Have you received any other vaccine within the last 14 days, or plan to receive any other vaccine in the next 14 days?

☐ **Yes or** ☐ **No** Are you feeling sick today?

☐ **Yes or** ☐ **No** Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days

☐ **Yes or** ☐ **No** Have you received any dose of COVID-19 vaccine?

If **YES,** which COVID-19 Vaccine have you received?

☐ Pfizer-BioNTech ☐ Moderna ☐ AstraZeneca ☐ Not Sure

☐ **Yes or** ☐ **No** Are you currently pregnant or plan to become pregnant?

☐ **Yes or** ☐ **No** Are you currently breastfeeding?

☐ **Yes or** ☐ **No** Are you immunocompromised or do you take any medications that affect your immune system?

☐ **Yes or** ☐ **No** Do you have a bleeding disorder or are you on a blood thinner?

By my signature below, I indicate:

- I give permission to be billed and/or to have my insurance billed for charges associated with getting the COVID-19 vaccine.
- I understand that I will be advised to receive a second dose of this vaccine in 21 days.
- I understand that I must stay on site today for at least 15 minutes post vaccination.
- I was given a copy of the COVID-19 EUA fact sheet and I understand the benefits and risks of the vaccination.
- I give permission for a record of the vaccination to be placed into Centricity EMR and sent to the Maine ImmPact Registry
- I give permission to receive the vaccination.

_____ _____

Signature Date

Office Use Only Below This Line

COVID-19 EUA fact sheet given Yes_X__ No ___ **Medication: Pfizer Date Given:**_____ **Route:** _IM__ **Site**: R Deltoid☐ L Deltoid☐ **Time Given: _____**

Lot #:_____ **Expiration Date:**_____**NDC #:80777-0273-10** Dose 1 ☐ Dose 2 ☐

Given By: _____