COVID-19 Vaccine Informed Consent

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Name:_____
Birth Date:_____ Age:_____
Month / Day / Year *Must be 16 or Older*
Street Address:_____ City:_____ State:_VA_____ Zip:____
County/Locality of Residence: _____
Daytime Phone:_____ Patient's Legal Representative:_____ Relationship: _____

Gender:	Male Female	Race:	☐American Indian/Alaska Native ☐Hawaiian Native or Other Pacific Islander	☐ Asian ☐ Black/African American	☐ White ☐ Not Stated	Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unknown

[redacted]

COVID-19 SCREENING QUESTIONS

	No	Yes	Don't Know
Have you had a severe allergic reaction to this vaccine?			
Do you have a known history of a severe allergic reaction to this vaccine			
Are you under the age of 16 years?			
In the past two weeks (14 days) have you tested positive for COVID-19 or are you currently being monitored for COVID-19?			
In the past two weeks (14 days) have you had exposure to a person who tested positive for COVID-19?			
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			

MEDICAL SCREENING QUESTIONS

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
Do you have a history of severe allergic reaction (e.g., anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication:_____			
Do you have a bleeding disorder or are you on a blood thinner?			
Are immunocompromised or are on a medicine that affects your immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments)?			
Are you pregnant or do you plan to become pregnant?			
Are you breastfeeding?			

ABOUT THE VACCINE

For complete information about the vaccine This Fact Sheet may have been updated. For the most recent Fact Sheet for Recipients and Caregivers, a copy of which is being provided to you with this informed consent. Current copies of the Fact Sheet are available online at www.cvdvaccine.com and you should look here for updates.

The vaccine may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine to prevent COVID-19 in individuals 16 years of age and older under an Emergency Use Authorization (EUA).

The vaccine will be given to you as an injection into the muscle. The vaccine is given in a series of 2 doses given 3 weeks apart. If you receive one dose of the vaccine, you should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

Risks of the vaccine include side effects and there is a chance that the vaccine could cause a severe allergic reaction. If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital. Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

CONSENT FOR VACCINATION

☐ I hereby authorize the administration of the COVID-19 to myself or to the person named below for whom I am the legal representative

☐ I have read or have had explained to me the information contained in the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) and understand the risks and benefits of the vaccine and alternatives to the vaccine (that is, not receiving the vaccine or waiting for other versions of the vaccine);

☐ I have had the opportunity to ask questions about this immunization (and any questions I had about the COVID-19 vaccine have been answered to my satisfaction.

☐ I believe the benefits outweigh the risks, and I accept full responsibility for any reactions that may result from my receipt of the immunization or the receipt of the immunization by the person named below for whom I am the legal representative.

☐ I agree that my vaccine-related health information may be required to be or may voluntarily be disclosed to my health care provider, my insurance plan, and state or federal registries or other public healthy authorities, for purposes of treatment, payment or health care operations. I also agree that the organization providing my vaccine may use and disclose my health information as described in its Notice of Privacy Practices.

X_____ _____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

Sign in front of person who vaccinates you

_____

Printed name

_____

Relationship to patient receiving vaccine (if not self)

If signing on behalf of the patient, you are stating that you are authorized to provide the required consent on behalf of the patient.

VACCINE ADMINISTRATION INFORMATION / FOR IMMUNIZER USE ONLY

	COVID-19		12/20	Pfizer	
Administration Date	Vaccine		VIS Date	Manufacturer	
		IM		L R	0.3
Lot #	Exp. Date	Route	Series	Site	Volume (mL)

Signature: