Pfizer COVID-19 Vaccine
COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: ____/____/_____	Age:	VSU ID#
ADDRESS		MOTHER'S MAIDEN NAME		
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 ☐ Other

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 and the date administered: ☐ Pfizer _____ ☐ Moderna _____ ☐ Another Product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something: For example, a reaction for which you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Have you received another vaccine in the last 14 days?			
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			

I, the undersigned, wish to receive the **Pfizer COVID 19 vaccine.** I hereby certify that the foregoing answers to the health questions are true and complete to the best of my knowledge. I understand that a "YES" response to any of the health questions above will require that a Student Health Services provider talk with me prior to getting the Pfizer COVID 19 vaccine at a VSU vaccination clinic. I understand the benefits and risks of the **Pfizer COVID 19 vaccine** and had the chance to ask questions which were answered to my satisfaction. I acknowledge I had access to a link during the registration process to review and read the Emergency Use Authorization (EUA) and the FDA Fact Sheet for Recipients and Caregivers prior to receiving the COVID-19 vaccine. I understand that these documents will also be available in print form at any VSU vaccination clinic upon 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	Dose	Route	Date Dose Administered/Time	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	____ml 1st _____ml 2nd	☐ IM - L Arm ☐ IM - R Arm					

Entered in Grits by:_____Date:_____