PFIZER-BIONTECH COVID-19 VACCINE IMMUNIZATION CONSENT FORM

For Covid-19 Provider Use only Clinic Name/code;____________________ Location type: (clinic, health department, pharmacy, ect,.)____________________ Adddress: ____________________
City: ______________ County: ________ State : ______ Zip: ______ Date of Service :______________

Person Receiving Vaccine: Date Of Birth : ____/____/______ Phone :______________
Legal Name: First______________________ MI:____ Last :______________
Addresss:______________________________________ State:____Zip______

Medical History: complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 Vaccine.

*If YES and further guidance is needed, Refer to Pfizer Website at www.PfizerMedinfo.com or Call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration.	*YES	NO
Have you had a previous COVID-19 Vaccine? If yes date		
Have you had any vaccines within the previous 14 days? Pfizer-BioNtech COVID-19 vaccine should be administered alone with a minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Ate yo sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to Covid-19?		
Have you ever had a severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component of injectable therapy? Such as difficulty breathing, swelling of your face and throat , fast heart beat, bad rash all over you body, dizziness and weakness.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine. A Discussion with your health care provider can help make an informed decision.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies of convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune response.		
****NOTE:** Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after the initial vaccine. Refer to your COVID-19 vaccination record card for the second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.		

2. Release and Assignment

Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign below.

Insurance : AR KIDS #______________________ **Medicare#** ______________________
Insurance : Card holder Name : ____________________ **Company:** __________
Rx BIN: __________ **RX ID:** __________ **PCN :**__________ **Rx Group:** __________

My signature below indicates I have read, understood and agreed to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA)
Signature of Patient/Parent/Guardian: ______________________________
Date:______________

Shot site : AD / LD IM SubQ Lot # ______________ **Exp:** ______________

Given By :______________________________________ **Date:** __________