coastalpediatrics

Pfizer COVID-19 Vaccine

COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME *(Last)*	*(First)*	**Date of Birth:** _____/_____/_____	**Age:**

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer vaccine to prevent COVID-19 in individuals 5 to 11 years old. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's *Fact Sheet for Recipients and Caregivers*.

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 been prescribed an EpiPen? Or, have you ever experienced 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. Does the patient have a history of myocarditis or pericarditis?	☐	☐	☐
5. Has the patient tested positive for COVID in the past 10 days or currently in quarantine for COVID exposure?	☐	☐	☐
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take steroids or any other immunosuppressive drugs or therapies?	☐	☐	☐
7. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐

I have reviewed the FDA Fact Sheet for Recipients and Caregivers (https://www.fda.gov/media/153717/download), including the Emergency Use Authorization (EUA) information, prior to receiving the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me or the person named for whom I am authorized to make this 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	IM	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Initials of Vaccine Administrator
COVID-19	0.2 ml ☐ 1st 0.2 ml ☐ 2nd	☐ L Arm ☐ R Arm		Pfizer	FK5127	1/11/22	