

Pfizer-BioNTech COVID-19 Vaccine CONSENT 2021

Hospital/Clinic Location: Grand Itasca Clinic & Hospital

Last Name (Print Legibly) _____ Legal First Name _____

Date of Birth _____ Age on date of vaccination* _____

****Note: If patient is under the age of 18 on date of vaccination, must have guardian's written consent**

* NOTE: Individual must be 12+ years of age on date of Pfizer-BioNTech COVID-19 Vaccine

1. Have you received 2 doses of any COVID-19 vaccines: **Yes No**
2. Have you received the Pfizer BioNTech COVID-19 vaccine less than 17 days ago? **Yes No**
3. Have you had a severe allergic (anaphylaxis) reaction to the COVID-19 vaccine? **Yes No**
4. Have you had a previous severe allergic reaction (anaphylaxis) after any other vaccine or shot? **Yes No**
5. Have you ever been told you have an allergy to polysorbate, or any ingredient of the COVID-19 vaccine (such as polyethylene glycol or PEG)? **Yes No**
6. Have you received any other vaccine within the past 14 days? **Yes No**
7. Have you been diagnosed with COVID-19 in the last 10 days and are still in quarantine? **Yes No**
8. Have you received antibodies or plasma to treat COVID-19 in the past 90 days? **Yes No**
9. Have you had MIS-C (Multisystem Inflammatory Syndrome in Children) due to COVID-19? **Yes No**
10. Have you been in contact with someone diagnosed with COVID-19 in the last 14 days and are still in quarantine?
Yes No
11. Are you feeling sick today? **Yes No**

ACKNOWLEDGMENT: I have been offered or read or have had explained to me the Pfizer-BioNTech COVID-19 Vaccine Fact Sheet dated 5/2021 about COVID-19 and the COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. My election below is based upon my belief that I understand the benefits and risks of the Pfizer-BioNTech COVID-19 vaccine. **Initial here:** _____

Signature of person receiving vaccine or Signature of guardian & relationship (if person receiving vaccine is <18 years of age):

X _____ Date of Consent: _____

Vaccine:	Manufacturer:	Lot #:	Expiration Date:
<input type="checkbox"/> Pfizer-BioNTech COVID-19 Vaccine (age 12+) 0.3 ml	Pfizer-BioNTech		
Check site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Pfizer-BioNTech COVID-19 Vaccine Fact Sheet Date: 5/2021		Route: IM Refer to PMD for alternate site requests
Date Vaccine Given:	Pfizer-BioNTech COVID-19 Immunization Administered by: (legible signature, first & last name)		(Circle) RN LPN CMA RPh
	Employee Vaccinator ID Number:		MD PA