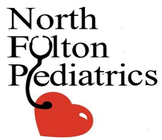

Drivers License#/or SS#______________________________ Temp: _____________

COVID-19 Vaccination Consent Form 2021

Last Name *(Please print)*	First Name	MI	Date of Birth	Male / Female

Address	City	State	Zip

Phone Number	Email	Emergency Contact Today

SCREENING FOR VACCINATION ELIGIBILITY(Pfizer)		
1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	NO
4. Are you under age 5?	Yes	N0
5 Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner other than daily baby Aspirin?	Yes	NO
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. If this is your second dose, when was the date of your first dose?	Yes	No
10. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?	Yes	No

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

Signature of Parent/Guardian/Patient____________________________Date ________________