"Our Family Caring for Your Family"

BCMH

Baraga County Memorial Hospital

PFIZER COVID-19 Vaccine Consent

Name: _____DOB:_____

Address:_____

Phone_____

	Yes	No	Unsure
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ 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 allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

I have read and understand the fact sheet by the FDA and that BCMH is required to submit data to MCIR and report adverse events to Vaccine Adverse Event Reporting System. I agree to wait in the clinic for 15 minutes (or 30 minutes if a history of severe allergic reaction) after receiving the vaccine. I understand and agree to all of the above and give my consent to bill my insurance for the administration of the vaccine.

Patient/Guardian Signature:_____Date: _____

----------FOR OFFICE USE ONLY----------

Pfizer: ☐ 1st Dose ☐ 2nd Dose ☐ 1st Booster ☐ 2nd Booster Lot# _____

0.3 mL given IM: ☐ Right Deltoid ☐ Left Deltoid

Administered by: _____ Date: _____ Entered into MCIR: _____

Expiration Date: _____