PFIZER COVID-19 VACCINE CONSENT

Name: _____DOB: _____

Address: _____

Phone: _____

1. Are you feeling sick today? _____Yes _____No
2. Have you ever received a dose of COVID-19 vaccine? _____Yes _____No
   If yes, which product?
   □ Pfizer □ Moderna □ another product _____
3. Have you ever had a severe allergic reaction to COVID-19 vaccine? _____Yes _____No
4. Have you recently tested positive for COVID-19? _____Yes _____No
   - If yes, when? _____
5. Have you received passive antibody therapy as treatment for COVID-19? _____Yes _____No

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider. 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 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 CLINIC USE ONLY**********

Pfizer: □ 1st Dose □ 2nd Dose Lot # FP7150 Expiration Date: 11/30/2022

Pfizer Bivalent: □ Booster Lot # GJ6739 Expiration Date: 07/31/2023

0.3 mL given IM: □ Right Deltoid □ Left Deltoid

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

This Box Clinic Use Only:

Place Insurance Card in This Box Once

Document is Complete and Take Photo

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