VACCINE SCREENING AND CONSENT
Pfizer-BioNTech COVID-19 Vaccine

DATE: _____
SITE: _____
REGISTRATION STAFF
_____
(Please print name clearly)

SECTION 1: INFORMATION ABOUT YOU *(PLEASE PRINT)*

Name: Last	First:	Middle Initial:	Age:
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian): ( )**		
Address:		**Apt/Room #:**	
City:	**State:**	**Zip:**	

Sex (Gender assigned at birth) ☐ Female ☐ Male	Race	**Ethnicity**

This is the patient's First Dose: Month Day Year Time

Second Dose will be given: Month Day Year Time

SECTION 2: COVID-19 SCREENING QUESTIONS *(TO BE COMPLETED BY NURSE)*

Please check YES or No for each question.	**Yes**	**No**
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the components of this vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	**Yes**	**No**
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine, that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

☐ Prior to vaccination, I was given a copy of the FDA's Fact Sheet for Recipients and Caregivers in connection with the Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine or was directed to the FDA's COVID-19 vaccination website at: Pfizer-BioNTech COVID-19 Vaccine I cvdvaccine.com.

☐ FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine, which is not an FDA-approved vaccine.

☐ The recipient or their caregiver has the option to accept or refuse Pfizer-BioNTech COVID-19 Vaccine.

 The significant known and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine, and the extent to which such risks and benefits are unknown, have been disclosed to me. Information about available alternative vaccines and the risks and benefits of those alternatives, to the extent reasonably known, have been disclosed to me.
 The Pfizer-BioNTech COVID-19 Vaccine is administered intramuscularly as a series of two doses (0.3 mL each) 3 weeks apart. Recipients must receive both doses of the Pfizer-BioNTech COVID-19 Vaccine to complete vaccination.
 Recipient is 12 years of age or older.
 Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the Pfizer-BioNTech COVID-19 Vaccine.
 Vaccine may not protect all vaccine recipients.
 The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyI)bis(hexane-6,1-diyl)bis(2-hexyIdecanoate), 2 [(polyethylene glycol)-2000]-N,N- ditetradecylacetamide, 1,2-DistearoyI-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.
 I have read or have had explained to me the information identified in the FDA's Fact Sheet for Recipients and Caregivers regarding the Pfizer-BioNTech COVID-19 Vaccine. I have had an opportunity to discuss the benefits and risks of this COVID-19 vaccine with a healthcare provider of my choice before vaccination. I have had a chance to ask questions which were answered to my satisfaction.
 I believe I understand the benefits and risks of this vaccine and ask that this vaccine be given to me or the person named for whom I am authorized to make this request.

Authorized Individual's Information (complete if different from vaccine recipient):

_____ _____
Last Name First Name

Phone Number: _____ Relationship to recipient: _____
Vaccine is for (check one):

- o Self
- o Child
- o Other:

Signature of Patient or Authorized Representative _____ Date _____

Print Name of Representative and Relationship to Person Receiving Vaccine:

Parent/Guardian Consent on Portal (Yes/No)

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Lot # Unit of Use/ Unit of Sale	Expiration Date	
	IM					

Nurse Print Name: _____ **Nurse Signature:** _____ **Date:** _____