

SARS-CoV-2 Vaccine (COVID-19)
CONSENT FORM AND ADMINISTRATION RECORD

CLEARLY PRINT information below about the person receiving the vaccine OR **CIRCLE** correct responses.

Last Name _____ First Name _____ MI _____
Birthdate ____/____/____ Sex: ____ F ____ M ____ Other
Ethnicity ____ Hispanic or Latino ____ Not Hispanic or Latino ____ Unknown ____ Unable to report
Race ____ American Indian/Alaska Native ____ Asian ____ Black/African American ____ White
____ Native Hawaiian/Other Pacific Islander ____ Other Race/Multi-racial ____ Unknown ____ Unable to report
Home Address _____ City _____ State _____ Zip Code _____
County _____ Phone (____) _____

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 health care provider to explain it.

- 1) Are you feeling sick today? ____ Yes ____ No
- 2) Have you ever received a dose of COVID-19 vaccine? ____ Yes ____ No
If yes, which vaccine product did you receive: ____Pfizer ____ Moderna ____ Janseen (Johnson & Johnson)
- 3) Have you ever had an allergic reaction to:
(This would include a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)
A component of a COVID-19 vaccine including either of the following:
 - Polyethylene glycol (PEG), found in some medications, such as laxatives & preparations for colonoscopy procedures. ____ Yes ____ No
 - Polysorbate, found in some vaccines, film coated tablets or intravenous steroids. ____ Yes ____ No
 - Previous dose of COVID-19 vaccine ____ Yes ____ No
- 4) Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication. ____ Yes ____ No
- 5) Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies. ____ Yes ____ No
- 6) Have you ever had a positive test for COVID-19 or has a doctor ever told you that you have had COVID-19? ____ Yes ____ No
- 7) Have you received passive antibody therapy (monoclonal antibodies/convalescent serum) as treatment for COVID-19? ____ Yes ____ No
- 8) Do you have a weakened immune system caused by something such as HIV infection, cancer or do you take immunosuppressive drugs or therapies? ____ Yes ____ No
- 9) Do you have a bleeding disorder or are you taking a blood thinner? ____ Yes ____ No

Consent

I have received and reviewed the FDA Emergency Use Authorization Fact Sheet provided to me. I had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I consent to receiving the COVID-19 Vaccine. I acknowledge that this vaccination was approved by the FDA through an emergency use authorization. I hereby release and hold harmless, North Arlington Pediatrics and their employees, from all responsibility for any reaction that may occur from this vaccination. I agree to remain in the post-vaccination observation area for approximately 15 minutes [30 mins for history of severe allergy] after administration for observation by a healthcare provider. I agree to seek medical attention should I experience any severe symptoms, including breathing, dizziness, confusion, sudden weakness, or loss of consciousness.

Signature _____ Date _____

Date administered _____ Vaccine Mfg Pfizer Signature of Vaccine Administrator _____ Route IM R deltoid L deltoid 0.2ml 0.3ml (circle)

Printed name _____ Lot # _____

I-CARE: Initials _____ Date _____