PFIZER COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____ _____
First Middle Last **EMAIL**

Address: _____ _____ _____ _____
Street City State Zip

Mobile phone: (_____) _____--_____ Covered by Insurance, Medicaid, or Medicare: ☐ **Yes** ☐ **No**

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐White ☐Multiracial ☐Native Am/Alaskan ☐Unknown

Emergency Contact Phone#:
Name:

Please answer the health questions below:	**Yes**	**No**	**Unknown**
1. Are you sick today or currently in an isolation or quarantine period for COVID-19?			
2. Have you had a positive COVID-19 test in the last 3 months/90 days?			
3. Have you received passive antibody therapy as treatment for COVID-19?			
4. 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?			
5. Have you ever had a serious reaction after receiving a vaccine or another injectable medication?			
6. Have you received any vaccinations in the past two weeks/14 days?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Do you currently have a weakened immune system, take immunosuppressive medications, or receive radiation or chemotherapy treatment?			
9. Are you pregnant or currently breastfeeding?			
10. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine? …Pfizer …Moderna Date(s) received: _____			

- I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction.
- **I understand the initial COVID-19 vaccine series requires 2 doses given 21 days apart.** Boosters consist of a single dose. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the FACT SHEET to complete the vaccination series. **I consent to receive call and/or text message reminders at the mobile phone number provided above.**
- **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with a history of previous anaphylactic reactions, should stay on site for 30 minutes.** I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.
- An administration fee may be billed to third party payers. I authorize Coast Pediatrics to bill any and all third party payers for this service. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein.
- I ALLOW my/my child's immunization record to be shared with other health care providers, agencies, or schools in the California Immunization Registry
- I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown. **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME OR THE PERSON LISTED ABOVE**

_____ _____ **X**_____
Date **Print Name** **Patient or Parent/Guardian Signature**

OFFICE USE ONLY		**Record of Immunization**			**OFFICE USE ONLY**	
Vaccine	**Lot #**	**Exp Date**	**Dose**	**Route – Site**	**DATE**	**Provider Signature, Title**
PFIZER				**…IM LEFT Deltoid** **IM RIGHT Deltoid**		