SSMHealth.

12 years and older Primary Series and Booster Dose: PFIZER-BioNTech COVID-19 VACCINE CONSENT FORM

Patient's Name: ____ Maiden Name: ________________________

Date of Birth: ________________ Home Address: ______________________________________ City: _____________________

State:_________ County:________________ Zip Code: ________________Email: _____________________________________

Screening Questions

Monovalent Primary Series - Do not administer if the answer is NO

Question			
1. Are you 12 years of age or older?	Yes	No	
2. If receiving second dose, was the first dose at least 21 days ago?	Yes	No	N/A
3. For ***immunocompromised patients*** receiving the completion dose, was the second COVID vaccine dose at least 28 days ago?	Yes	No	N/A

Bivalent Booster - Do not administer if the answer is NO

Question		
4. Are you 12 years of age or older?	Yes	No
5. Has it been at least two months since completing the primary series or receiving a booster of Pfizer, Moderna, or J&J (Janssen)?	Yes	No

Consult provider if the answer is YES

Question		
6. Do you feel ill today, or do you have a fever? COVID-19 Symptoms: T >/=100.0 F, respiratory symptoms (cough, shortness of breath), new loss of smell and/or taste, headache, sore throat or muscle pain.	Yes	No
7. Do you have a history of Multisystem Inflammatory Syndrome (MIS) and have you had an onset of symptoms in the past 90 days?	Yes	No
8. Have you tested positive for COVID-19 in the past 10 days?	Yes	No
9. *History of severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or any of its components?	Yes	No
10. *History of an immediate allergic reaction of any severity to a previous dose of a COVID-19 vaccine or any of its components? (include polyethylene glycol (PEG)	Yes	No
11. *History of immediate allergic reaction of any severity to polysorbate?	Yes	No

*Should not receive the COVID-19 vaccination at this time unless they have been evaluated by an allergist-immunologist and it is determined whether the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available).

Monitor if YES

Question		
12. Do you have a condition that makes you bruise or bleed easily? (if yes, monitor for bleeding post vaccination)	Yes	No
13. History of an immediate allergic reaction of any severity to a vaccine or injectable therapy (intramuscular, intravenous, or subcutaneous or therapies not related to components of the COVID-19 vaccine or polysorbate) or a history of anaphylaxis due to any cause? (if yes, should be observed for 30 minutes)	Yes	No

I hereby certify that the foregoing history is true and complete to the best of my knowledge. I understand that this Monovalent COVID-19 vaccine is approved by the FDA for ages 12 and older for two dose primary series and Bivalent COVID-19 vaccine is authorized as a single booster for 12 and older. I have received and read the "Vaccine Information Fact Sheet for Recipients and Caregivers" and have had an opportunity to ask questions. The known and potential risks and benefits of the vaccine, as well as available alternatives, have been explained to me. I understand that I can accept or refuse the vaccine. If I am an employee or otherwise affiliated with SSM, I give permission to share information concerning my receipt of the vaccine with SSM Health's Employee Health Department if needed. I hereby consent to the administration of the COVID-19 vaccine for myself or to the above named minor or incapacitated person:

Date:______________________________ **Relationship (Circle one): Self Parent Legal Guardian *Responsible Person**

Signature:____ **Print Name:**_______________________________________

Type of Vaccine	Dosage	Lot#	Expiration Date	Dose Number
Primary Monovalent Series: Pfizer-BioNTech COVID-19 Vaccine	0.3 mL			
Bivalent Booster: Pfizer-BioNTech COVID-19 Vaccine	0.3 mL			

Site: Left Deltoid ________ Right Deltoid ________ Date given: __________________ Vaccine information provided: ☐ Yes ☐ No

Vaccine Administrator Signature: __________________________________ **Print Name:** ____

*The term "responsible person" means the parent, legal guardian or responsible adult if the patient is a minor or an incapacitated person.