

VACCINATION CONSENT FORM

Pfizer-BioNTech COVID-19 Vaccine

The novel coronavirus SARS-CoV-2 (a/k/a COVID-19) is an infectious disease that appeared in late 2019. The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19 at this time.

I request that the Pfizer-BioNTech COVID-19 Vaccine be given to me or to the person named hereafter for whom I am authorized to make this request (select one): MYSELF PERSON NAMED BELOW

Recipient's Information:

Last Name First Name Date of Birth Gender

Address: _____
City: _____ State: _____ Zip: _____

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

Last Name First Name Date of Birth Gender

Address: _____
City: _____ State: _____ Zip: _____

Relationship to recipient: _____

Vaccine is for (check one): Physician Contractor Employee Volunteer Other: _____

Company/Organization: _____

ACKNOWLEDGEMENTS (INITIAL EACH STATEMENT):

- _____ 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 | cvdvaccine.com](https://www.fda.gov/cv/dvaccine.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)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-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.

MEDICAL SCREENING QUESTIONS: Check yes or no to each question below. Tell your vaccination provider about all your medical conditions, including if you answer "yes" to any question. Except for the last two (2) questions, a "yes" response to any other question means you may wish to consult with your individual healthcare provider before proceeding. Answering "yes" to either of the last two (2) questions means you should not be vaccinated today.

Question	Yes	No
Do you have any allergies?		
Do you have a fever?		
Do you have a bleeding disorder or are on a blood thinner?		
Are you immunocompromised or are you on a medicine that affects your immune system?		
Are you pregnant or plan to become pregnant?		
Are you breastfeeding?		
Have you received another COVID-19 vaccine?		
Have you had a severe allergic reaction after a previous dose of this vaccine?		
Have you had a severe allergic reaction to any ingredient of this vaccine?		

_____ **Signature of Recipient OR Recipient's Authorized Individual**

_____ **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY VIS Edition Provided: _____

Vaccine: _____

Administration Date: _____

Manufacturer: _____

Lot #: _____

Exp. Date: _____

Route: _____

Site: _____

Volume (ml): _____

_____ **Nurse/ Provider's Signature**

_____ **Date**

_____ **Time**