



# PFIZER COVID-19 Vaccination Screening & Consent Form

## Section 1: PERSONAL INFORMATION

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Guardian name (Last, First): \_\_\_\_\_ Guardian DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

|     |        |          |                                  |                                  |           |                        |
|-----|--------|----------|----------------------------------|----------------------------------|-----------|------------------------|
| SEX | Female | RACE     | American Indian or Alaska Native | Native Hawaiian or Other Pacific | Ethnicity | Hispanic or Latino     |
|     | Male   | Islander | Asian                            | White                            |           | NOT Hispanic or Latino |
|     |        |          | Black or African American        | Unknown                          |           | Unknown                |

## Section 2: CONSENT TO RECEIVE THE COVID-19 VACCINE (Please INITIAL consent, agreement & understanding):

*\*If patient is a minor, a parent or legal guardian must initial\**

**Vaccine Consent:** I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine that I receive. I request that the COVID-19 vaccination be given to me. I AM OVER THE AGE OF 12 YEARS OLD.

**Observation:** I understand that I must remain in the observation area for 15 minutes post vaccination if I do not have a history of allergic reactions. I must remain for 30 minutes if I have a history of severe allergic reactions.

## Section 3: PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS:

| Vaccination Screening Questions   | YES | NO | DON'T KNOW |
|---|-----|----|------------|
| <b>ARE YOU OVER THE AGE OF 18?</b>  |     |    |            |
| Is the recipient feeling sick today?  |     |    |            |
| Are you here for an <b>ADDITIONAL COVID-19 VACCINE?</b>   |     |    |            |
| If your answered <b>YES</b> . Has it been at least 4 weeks since your second dose of Pfizer or Moderna?<br><i>*Please continue to Section 4, after completing Section 3*</i>  |     |    |            |
| Has the recipient ever received a COVID-19 vaccine?<br>YES, I received the <b>Pfizer BioNTech</b> COVID-19 Vaccine<br>YES, I received the <b>Johnson &amp; Johnson</b> COVID-19 Vaccine<br>YES, I received the <b>Moderna</b> COVID-19 vaccine<br><u>NO</u>   |     |    |            |
| Did you bring your vaccination record card or other documentation?  |     |    |            |
| Has the recipient ever had a severe allergic reaction (e.g. anaphylaxis) to: (*A severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen®, or that caused the recipient to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.) |     |    |            |
| Polyethylene glycol (PEG), which found in some medications, such as laxatives and preparations for colonoscopy procedures.  |     |    |            |
| Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids   |     |    |            |
| A previous dose of COVID-19 vaccine   |     |    |            |
| Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  |     |    |            |

Please check all that apply to you:

- Am a female between ages 18 and 49 years old
- Am a male between ages 12 and 29 years old
- Have a history of myocarditis or pericarditis
- Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- Have a bleeding disorder
- Take a blood thinner
- Have a history of heparin-induced thrombocytopenia (HIT)
- Am currently pregnant or breastfeeding
- Have received dermal fillers
- History of Guillain-Barré Syndrome (GBS)

Do you need a TST (TB skin test) or IGRA (TB blood test)? (Can be done before or during the same encounter as COVID encounter)

*\*If it is not possible to test with TST or IGRA at the same time as COVID-19 vaccination, these tests should be delayed ≥4 weeks after the completion of COVID-19 vaccination with either the 2-dose mRNA COVID-19 vaccines (Pfizer-BioNTech and Moderna) or single dose viral vector COVID-19 vaccine (Janssen), due to the unknown reliability of a negative TST or IGRA result.*

VACCINE: **PFIZER** MANUFACTURER: **PFIZER** VACCINE LOT NUMBER: SITE: R / L VERIFIED VAR? Y or N INITIAL: \_\_\_\_\_

**Section 4: PLEASE ANSWER THE FOLLOWING QUESTIONS:**

\*ONLY if you are here for an additional COVID-19 Vaccine

| Currently, CDC is recommending that moderately to severely immunocompromised people receive an additional dose. Please indicate if you have any of the following:  | YES | NO |
|--|-----|----|
| Active treatment for solid tumor and hematologic malignancies  |     |    |
| Receipt of solid-organ transplant and taking immunosuppressive therapy   |     |    |
| Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)  |     |    |
| Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)  |     |    |
| Advanced or untreated HIV infection  |     |    |
| Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory |     |    |