Pfizer *1st Dose* COVID-19 Vaccine *CONSENT FORM* **Location: Plainview High School West Gym** **Date: Tuesday, October 5, 2021** **Time: 1pm – 4pm**	City of Plainview-Hale County Health Department 111 E. 10th Street, 79072 806-293-1359

Last Name of person receiving the vaccine:	First Name of person receiving the vaccine:	Middle Name of person receiving the vaccine:	Sex: **M F**	Birth Date:	Age:

Address:	City:	State:	Zip:	County:

Phone:	Mother's First Name:	Mother's Maiden Name:

Pfizer COVID-19 Vaccine is a vaccine developed by Pfizer to prevent disease caused by COVID-19. Pfizer is an FDA approved vaccine to prevent COVID-19. The purpose of this form is to obtain your consent to receive this vaccine or parent/legal guardian consent to receive this vaccine if you are a student at least 16 years of age.

Do you have a known history of a severe allergic reaction (e.g., anaphylaxis) to any component of the Pfizer COVID-19 vaccine: mRNA, lipids ((4-hydroxybutyl) azanediyl)bis(hexane-6, 1-diy)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 dehydrate, and sucrose?	Yes	No

Exclusion Question: Answering yes to the question above excludes you from receiving the vaccine.

Are you younger than 18 years of age?	Yes	No

If you are a student ages 16 or 17 receiving the vaccine, your parent/legal guardian must consent for you to receive this vaccine by signing and providing their telephone number on page two of this form.

Screening Questions: *Immunizer: If patient answers "yes" to any of the questions below, provide patient counseling or instruct them to consult with their provider prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy (i.e., convalescent plasma or a monoclonal antibody) as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant? *	Yes	No
Are you immune-compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g., anaphylaxis) to another vaccine or injectable medication? If Yes, what vaccine or injectable medication:	Yes	No

If yes to any of the above, I attest that I have discussed my condition with my provider and vaccination is recommended or I acknowledge that there may be risks and consent to proceed with vaccination.	Yes	No	N/A

**Pregnant women and breastfeeding women have not been included in any COVID vaccine clinical trials to date, so there is currently no safety data specific for this population. If you are pregnant, plan to become pregnant, or are breastfeeding, we strongly recommend you speak to your care provider before getting the vaccine.*

Safety is our number one priority. By receiving this COVID-19 vaccine you are agreeing to our safety protocol, which requires those receiving the vaccine to remain in the vaccination area for at least 15 minutes following their vaccination. This additional time is for safety and allows the vaccine team to monitor everyone who is vaccinated in the event of a reaction.

Acknowledgement and Consent to Receive Vaccination

The following has been discussed with me or I have been provided information about:

- The FDA has approved the use of the Pfizer COVID-19 Vaccine for vaccination against COVID-19.
- The option to accept or refuse vaccination and alternative options.
- Information on available alternative vaccines and the risks and benefits of those alternatives.
- Significant and potential risks and benefits of vaccination, and the extent to which they may occur, is not known at this time.

I have been provided a copy and/or opportunity to review the Fact Sheet:

- FDA Fact Sheet for Patients/Caregivers
- I have been provided a vaccination card with the timeframe for when I need to return for the second dose of Pfizer COVID-19 Vaccine.

I understand and agree that this consent form and records relating to my vaccination will be maintained in designated records, including, if applicable, my medical record and/or my occupational health record.

I consent to the release of my information to state or federal health authorities (e.g. state immunization registries) for the purpose of tracking immunizations during the public health emergency.

I was provided information on the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine.

I acknowledge and agree that I understand the nature of receiving the Pfizer COVID-19 Vaccine, including the risks and benefits known at this time and the available alternatives. I have received the information discussed above and had my questions answered to my satisfaction. My consent to receive the Pfizer COVID-19 Vaccine will continue until I have completed the vaccination schedule of two doses, I experience a significant adverse reaction to the vaccine, or my goals of care have changed. I understand that I am free withdraw consent and stop treatment prior to the second dose. I understand that stopping the vaccination series will not impact other medical care and treatment options.

Printed *Name* of parent/legal guardian consenting for the student listed on page 1 of the form, ***or*** printed name of the adult ages 18 or older listed on pg 1 receiving the vaccine:	**Signature** of parent/legal guardian consenting for the student listed on page 1 of the form, ***or*** signature of the adult ages 18 or older listed on pg 1 receiving the vaccine:	Phone Number of parent/legal guardian or adult receiving the vaccine: Date:

********************************CLINIC USE********************************

MANUFACTURER	LOT NUMBER	EXPIRE DATE	DOSE	IM SITE
Pfizer	FD0809			**L-Deltoid** **R-Deltoid**

Administered by: **Date:**

ImmTrac: Date _____ Initials _____ **Release time: _____**