MemorialCare

☐ Registration ☐ Documenter

Pfizer and/or Moderna Vaccine Consent & Administration

PATIENT FIRST NAME		PATIENT LAST NAME	EMAIL
DATE OF BIRTH (M/D/Yr)	AGE	HOME PHONE	CELL PHONE
ADDRESS			

	Please mark 'yes' or 'no' to the following important health considerations.	YES	NO
1	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?		
2	Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days?		
3	Are you sick now with a moderate or severe illness?		
4	Have you ever received a COVID-19 vaccine? If yes, date _____ Brand: Pfizer Moderna Janssen		
5	Do you have a weakened immune system caused by something such as HIV or cancer, or do you take immunosuppressive drugs or therapies?		
6	Are you pregnant or breastfeeding?		
7	Do you have dermal fillers? (e.g. Restylane, Juvéderm)		
8	Have you ever had a severe allergic reaction to vaccine, injectable medication, food or other?		

CONSENT

1. 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 ("VACCINE"). I understand the FDA has authorized emergency use of the VACCINE, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
2. I understand the significant known and potential risks and benefits of the VACCINE as explained in the FACT SHEET and that some potential risks and benefits may remain unknown.
3. I have been advised to wait for 15-30 minutes for observation after receiving my VACCINE. If I experience a severe reaction while under observation, I understand that 911 will be called.
4. I understand that I am fully responsible for complying with any restrictions prescribed for me by my personal physician. If I mark yes to any of the above, I attest that I have discussed my condition with my provider and vaccination is recommended and/or I acknowledge that there may be risks and consent to proceed with vaccination.
5. I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. If I experience a severe reaction, I will call 911 or go to the nearest hospital.
6. 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.
7. I confirm that I have been told about the pros and cons of this vaccine and have been able to ask any questions. I request that the VACCINE be given to me or to the person listed above, for whom I certify that I am authorized to make this request and consent on their behalf.
8. **PARENT/LEGAL GUARDIANS ONLY.** I understand that the FDA has authorized emergency use of the Pfizer VACCINE for individuals that are 12 years or older, and I certify that the person listed above has already reached the age of 12.

_____

Patient / Patient Agent / Legal Guardian (Signature) Date Print Name, if other than Patient

Date	Vaccine Name	Administration	Route: IM	Dose	Man. & Lot	Expiration
	☐ Pfizer ☐ Moderna	☐ First ☐ 2nd Dose	☐ **R Deltoid** ☐ **L Deltoid**	☐ **0.3ml** ☐ **0.5ml**		

I have provided the patient (and/or agent or surrogate) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____ **& ID:**_____