Spencer Hospital
Clay County Public Health
Healthier Together.

Pfizer COVID-19 Vaccine Screening & Consent – 12 and older

☐ 1st Dose ☐ 2nd Dose ☐ Additional or Booster

Name: ______________________________ Date of Birth: ______________ Gender: ☐Female ☐ Male

Maiden Name: ______________________________ Phone Number: ______________________________

Address: ______________________________City: ______________________State: ______ Zip: ___________

Medical Provider: ____________________ Emergency Contact/Phone #: ______________________________

Please answer the questions below. If you answer 'yes' to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

1. Are you feeling sick today? ☐ Yes ☐ No ☐ Don't Know

2. Have you received a COVID-19 vaccine previously? ☐ Yes ☐ No ☐ Don't Know
   - If yes: Which vaccine? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other
   - Have you received a complete COVID-19 vaccine series? *(2 doses Moderna or Pfizer; 1 dose Johnson & Johnson)*

3. Have you ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving another vaccine or injectable medication? ☐ Yes ☐ No ☐ Don't Know

4. Check all that apply to you:
   - ☐ Am a female between ages 18 and 29 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 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)
   - ☐ 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-Barre Syndrome (GBS)

Vaccination Release

COMIRNATY (COVID-19 Vaccine, mRNA) is FDA-approved for those 16 years of age and older. The Pfizer-BioNTech COVID-19 Vaccine is FDA-authorized under Emergency Use Authorization (EUA) for those 12-15 years of age. Both have the same formulation. I have read or have had explained to me the information in the **VACCINE INFORMATION FACT SHEET FOR RECEIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19,mRNA) AND PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 12 YEARS OF AGE AND OLDER (10-29-21).** I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and consent to the vaccine be given to me or to the person for whom I am authorized to make this request.

Printed name: ______________________ **Signature:** ______________________ **Date:** __________

OR

Parent Name: ______________________ **Signature:** ______________________ **Date:** __________

(***if patient under age 18***)

Date:	Manufacturer	Lot #	Exp Date	EUA Fact Sheet	Dose	Site	Adm By	IRIS date/initial
	Pfizer			10/29/2021	0.3 ml	R Deltoid L Deltoid		

Revised 11-3-21