



Pfizer COVID-19 Vaccine COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: ____/____/____	Age:	GTID#	
ADDRESS					
CITY	STATE	ZIP	DAYTIME PHONE NUMBER		
EMERGENCY CONTACT: Name Relation Phone Number					
Race: (check only 1) <input type="checkbox"/> Asian/Polynesian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Am/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Unknown		Ethnicity: (check only 1) <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product and the date administered: <input type="checkbox"/> Pfizer _____ <input type="checkbox"/> Moderna _____ <input type="checkbox"/> Another Product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something: For example, a reaction for which you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital? *Was the severe reaction after receiving a COVID-19 vaccine? *Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Have you received another vaccine in the last 14 days?			
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			

I, the undersigned, wish to receive the **Pfizer COVID 19 vaccine**. I hereby certify that the foregoing answers to the health questions are true and complete to the best of my knowledge. I understand that a "YES" response to any of the health questions above will require that a Stamps Health Services provider talk with me prior to getting the Pfizer COVID 19 vaccine at a GT vaccination clinic. I understand the benefits and risks of the **Pfizer COVID 19 vaccine** and had the chance to ask questions which were answered to my satisfaction. I acknowledge I had access to a link during the registration process to review and read the Emergency Use Authorization (EUA) and the FDA Fact Sheet for Recipients and Caregivers prior to receiving the COVID-19 vaccine. I understand that these documents will also be available in print form at any GT vaccination clinic upon request.

My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.

_____ X _____
Date Print Name Patient or Parent/Guardian Signature

FOR ADMINISTRATIVE USE ONLY							
Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ml <input type="checkbox"/> 1 st _____ml <input type="checkbox"/> 2 nd	<input type="checkbox"/> IM - L Arm <input type="checkbox"/> IM - R Arm		Pfizer	ER2613	07/2021	