Full First Name *Please write name as it appears in medical records*	Full Last Name *Please write name as it appears in medical records*
Date of Birth (Month/Day/Year)	Age
Email	
Which dose is this for you today? First Dose Second Dose	

TEMPORARY CONTRAINDICATIONS OR PRECAUTIONS TO VACCINATION If participant answers 'Yes' to any questions 1-5, delay vaccination for time frame listed under question. If participant answers 'Yes' to question 6, *do symptom risk assessment and counseling.* If participant answers 'Yes' to question 7, *do allergy risk assessment and counseling.*	Y	N
1. Were you recently diagnosed with COVID-19 and still in your isolation period? *(Delay vaccination until past acute infection and out of isolation)*		
2. Have you had a high-risk exposure to COVID-19 in the past 14 days? *(You are able to be vaccinated but if you develop any post-vaccination symptoms that could also be COVID-19, you must leave work and be tested immediately.)*		
3. Have you received either convalescent plasma or a monoclonal antibody therapy (e.g. Bamlanivimab or Casirivimab/Imdevimab) in the past 90 days for treatment of COVID-19? *(Delay vaccination for 90 days after infusion)*		
4. Are you currently ill with a fever or moderate/severe illness? *(If so, needs symptom risk assessment.)*		
5. Have you ever had a history of a severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular, intravenous, or subcutaneous)? *(If so, a risk assessment needs to be done first before vaccination. If appropriate to vaccinate, precautions should be taken while receiving the vaccine.)*		

******Nurse Completes This Section******	
Vaccinated Today: YES ☐ NO ☐	**Place vaccine label here**

Information on the Risks and Benefits of the Pfizer-BioNTech COVID-19 Vaccine

The Pfizer-BioNTech COVID-19 Vaccine may prevent the person vaccinated from getting COVID-19. There is no U.S. Food and Drug Administration (FDA)-approved vaccine to prevent COVID-19. However, the FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 16 years of age and older under an Emergency Use Authorization (EUA). The Pfizer-BioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone. Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. For this reason, a vaccination provider may ask the persons receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body.

Consent for Minor's Vaccination

In providing my consent below, I agree that:

1. I have been provided with information regarding the risks and benefits of the Pfizer-BioNTech COVID 19 vaccine and have had the opportunity to ask questions of a medical professional regarding those risks and benefits.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
3. If I have health insurance that covers the above-named child, I give permission for my insurance company to be billed for the costs of administering the Pfizer-BioNTech COVID-19 Vaccine. There is no out-of-pocket charge for the vaccine itself, and I will not be billed for that portion of the cost of the immunization of the above-named child.
4. I understand that as required by state law, all immunizations will be reported to the appropriate state immunization registration system.
5. I hereby release this provider, its employees, its contractors, and its volunteers from any liability for any results which may occur from the administration of the vaccine.

I give consent for the above-named child to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

Parent/Guardian First and Last Name:	Parent/Guardian Signature:
Parent/Guardian Date of Birth:	Parent/Guardian Gender *(please circle)*: F M Non-binary
Relationship to Minor:	Date:

STAFF TO COMPLETE BELOW THIS LINE

Minor meets one of the following conditions and can consent to vaccine:

Emancipated Minor Parent of a Child Living apart from parent and financially independent Nurse was able to contact parent/guardian by phone and obtain verbal consent: YES NO

Nurse Signature: ______________________________ Date: ______________________