COVID-19 Booster Shot Consent Form

Pfizer-BioNTech only (as of Sept 30, 2021)

Name *

First Name Last Name

Date of Birth *

Month Day Year

Medicare #

Insurance information, if available

Facility Name *

Eligibility

As of September 30, 2021, only Pfizer-BioNTech has guideline for booster dose.

Which series of vaccine has been administered? *

- ○ Pfizer BioNTech
- ○ Moderna
- ○ Janssen (J&J)
- ○

Have you received your 2nd-dose of Pfizer BioNTech at least 6 months past? *

- ○ Yes
- ○ No

Per CDC recommendation, as of September 30, 2021, the following recipients are eligible for booster shots (3rd dose- Pfizer). Please select which group you belong; *

- ○ Older adults and 50-64 year old people with medical conditions
- ○ Long-term care facility residents aged 18 years and older
- ○ People with medical conditions aged 18-49 years
- ○ Employees and residents at increased risk for COVID-19 exposure and transmission

To find out more information about elgibility, please find the full article from CDC here.

Pre-screening Checklist

Are you feeling sick today?

- ○ Yes
- ○ No

Have you ever had an allergic reaction to a component of a COVID-19 vaccine, Polyethylene glycol (PEG), polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids or a previous dose of COVID-19 vaccine?

- ○ Yes
- ○ No

Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?

- ○ Yes

○
No

Check all that apply to you;

Am a female between ages 18 and 49 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 or injectable therapy 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 bleeding disorder

Take a blood thinner

Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies

Have a history of heparin-induced thrombocytopenia (HIT)

Am currently pregnant or breastfeeding

Have received dermal fillers

History of Guillain-Barré Syndrome (GBS)

Consent

I understand that:

- This vaccine is authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA). Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives.
- Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.
- I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.
- This vaccine has not been studied on individuals who are pregnant or breastfeeding and it is recommended that I discuss vaccination with my provider prior to receiving vaccine.
- I agree to remain at the vaccination location for at least 15 minutes after vaccine is administered in the event of adverse reaction.
- I agree that I have read the Emergency Use Authorization (EUA), and I have had the opportunity to ask questions and I have received satisfactory answers.

I understand and acknowledge record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management. I agree and authorize my COVID-19 vaccine record to be shared with my primary care physician and included in my health record(s) for continuity of care of care purposes.

Name of Signatory *

Prefix

First Name

Last Name

Email

A copy will be sent to you.