



Pfizer COVID-19 Vaccine (5-11 yrs. old)

COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: ____/____/____	Age:
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Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer vaccine to prevent COVID-19 in individuals 5 to 11 years old. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's [Fact Sheet for Recipients and Caregivers](#).

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: Pfizer _____ Moderna _____ Another Product _____			
3. Have you ever been prescribed an EpiPen? Or, have you ever experienced 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. Does the patient have a history of myocarditis or pericarditis?			
5. Has the patient tested positive for COVID in the past 10 days or currently in quarantine for COVID exposure?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take steroids or any other immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			

I have reviewed the [FDA Fact Sheet for Recipients and Caregivers \(https://www.fda.gov/media/153717/download\)](https://www.fda.gov/media/153717/download), including the Emergency Use Authorization (EUA) information, prior to receiving the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me or the person named for whom I am authorized to make this 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	IM	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Initials of Vaccine Administrator
COVID-19	____ ml <input type="checkbox"/> 1 st ____ ml <input type="checkbox"/> 2 nd	<input type="checkbox"/> L Arm <input type="checkbox"/> R Arm					