VACCINATION CONSENT FORM

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 12 years of age and older under an Emergency Use Authorization(EUA)

I request that the Pfizer-BioNTech COVID-19 Vaccine be given to me or to the person named hereafter for whom I am authorized to make this request (select one): ☐ MYSELF ☐ PERSON NAMED BELOW

Recipient's Information:

Last Name _____ First Name _____ Date of Birth _____ Gender _____

Address: _____

City: _____ State: _____ Zip: _____

Authorized Individual's Information (complete if different from vaccine recipient):

Last Name _____ First Name _____ Date of Birth _____ Gender _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to recipient: _____

Phone number: _____

Email: _____

ACKNOWLEDGEMENTS (INITIAL EACH STATEMENT):

_____ Prior to vaccination, I was offered a copy of the FDA's *Fact Sheet for Recipients and Caregivers* in connection with the Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine or was directed to the FDA's COVID-19 vaccination website at: https://www.fda.gov/media/144414/download.

_____ FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine, which is not an FDA-approved vaccine.

_____ The recipient or their caregiver has the option to accept or refuse Pfizer-BioNTech COVID-19 Vaccine.

_____ The Pfizer-BioNTech COVID-19 Vaccine is administered intramuscularly as a series of two doses (0.3 mL each) 3 weeks apart. Recipients must receive both doses of the Pfizer-BioNTech COVID-19 Vaccine to complete vaccination.

_____ Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the Pfizer-BioNTech COVID-19 Vaccine.

_____ Vaccine may not protect all vaccine recipients.

_____ Recipient is 12 years of age or older.

_____ The significant known and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine, and the extent to which such risks and benefits are unknown, have been disclosed to me. Information about available alternative vaccines and the risks and benefits of those alternatives, to the extent reasonably known, have been disclosed to me. 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.

_____ The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

_____ I have read or have had explained to me the information identified in the FDA's *Fact Sheet for Recipients and Caregivers* regarding the Pfizer-BioNTech COVID-19 Vaccine. I have had an opportunity to discuss the benefits and risks of this COVID-19 vaccine with a healthcare provider of my choice before vaccination. I have had a chance to ask questions which were answered to my satisfaction.

_____ I believe I understand the benefits and risks of this vaccine and ask that this vaccine be given to me or the person named for whom I am authorized to make this request.

MEDICAL SCREENING QUESTIONS: Check yes or no to each question below. Tell your vaccination provider about all your medical conditions, including if you answer "yes" to any question. Except for the last two (2) questions, a "yes" response to any other question means you may wish to consult with your individual healthcare provider before proceeding. Answering "yes" to either of the last two (2) questions means you should not be vaccinated today.

Question	Yes	No
Do you have any allergies?	☐	☐
Do you have a fever?	☐	☐
Do you have a bleeding disorder or are on a blood thinner?	☐	☐
Are you immunocompromised or are you on a medicine that affects your immune system?	☐	☐
Are you pregnant or plan to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Have you received another COVID-19 vaccine?	☐	☐
Have you had a severe allergic reaction after a previous dose of this vaccine?	☐	☐
Have you had a severe allergic reaction to any ingredient of this vaccine?	☐	☐

VFC Qualification

This child qualifies for vaccinations through the VFC program because he/she: (CHECK ONLY ONE)

☐ Is enrolled in AHCCCS (including secondary AHCCCS) OR in KidsCare

☐ Is American Indian or Alaskan Native

☐ Does not have health insurance

-OR-

This child DOES NOT qualify for vaccinations through the VFC program because he/she:

☐ Has Private health insurance ONLY

_____ _____

Signature of Recipient OR Recipient's Authorized Individual **Date**

DO NOT WRITE IN THIS SPACE—OFFICE USE ONLY

Vaccine: _____ Administration Date: _____

Manufacturer: _____ Site: R deltoid or L deltoid

Exp. Date: _____ Route: IM

Lot#: _____ Volume (ml): 0.3 mL

_____

Nurse/Provider's Signature Date