COVID-19 VACCINE CONSENT

Last Name: _____ **First Name:** _____

DOB: _____ **Phone #:** _____ **Gender:** ☐ M ☐ F **Primary Care Physician:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ ***Insurance Name:*** _____

Policy#: _____ ***Group#:*** _____ ***Primary Insured:*** _____

Primary Insured DOB: _____ ***Ethnicity:*** _____

Possible Side Effects from the Vaccine

The COVID-19 Vaccine is given by injection into a muscle of the upper arm. The commonly reported side effects include pain at the injection site, tiredness, headache, muscle pain, joint pain, chills, nausea, swollen lymph nodes, fever, feeling unwell, swelling at the injection site, and redness and warmth at the injection site. As the case with most drugs or vaccines, there is a possibility that allergic or more serious reactions, or even death, could occur with the COVID-19 Vaccine. The FDA has authorized the emergency use of Pfizer-BioNTech COVID-19 Vaccine, which is not FDA approved. The significant and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine, and their extent are unknown.

Warning

Please answer the following questions below in order that your health status may be screened by a nurse before your COVID-19 Vaccine is given. Some people should check with their doctor before taking the COVID-19 Vaccine.

Please circle Yes or No to the following questions:

1.	Are you sick today?	Yes No
2.	Have you received any vaccinations in the past two weeks and/or have received another COVID-19 vaccine at any time?	Yes No
3.	Have you been diagnosed with the COVID-19 infection in the last 90 days?	Yes No
4.	Have you ever had an allergic reaction to any component of a vaccine?	Yes No
5.	Have you ever had an anaphylactic reaction, or had other severe symptoms after receiving another vaccine or an injectable medication?	Yes No
6.	Do you have a history of a weakened immune system or currently taking a medication that affects your immune system?	Yes No
7.	Do you have a bleeding disorder or currently on a blood thinner?	Yes No
8.	Are you pregnant, breastfeeding, or plan to become pregnant?	Yes No

I understand the available benefits and risks of the vaccine and request the vaccine be given to me or the person authorized to make this request. I have received and reviewed the Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization Fact Sheet and the V-safe informational handouts. I authorize Coryell Medical Clinic Providers to furnish any information to my insurance company in order to process my claim. I grant permission to release medical records as necessary for insurance purposes. I understand that I am responsible for my expenses unless assignment is accepted and that my insurance coverage is a contract between myself and the insurance company. I understand that payment is expected at the time of service unless prior arrangements have been made. I do agree for my insurance money to go to Coryell Medical Clinic Providers, unless I have paid my balance in full at the time of service.

_____ _____ 12/2020

(Signature of person receiving vaccine or authorized person) Date EUA Date

OFFICE USE ONLY **CIRCLE ONE:** Dose 1 | DOSE 2

R / L Deltoid _____ _____

Injection Site Signature/Title of Vaccine Administrator Date

☐ *Immtrac Complete*
☐ *Immunization Entered in Centriq*

Manufacturer: _____

Lot #: _____

Exp. Date: _____

(Revised 01/29/2021)