Richland County TB & Public Health Office
COVID-19 Pfizer Vaccine Consent Form

Section 1: Patient Information (please print)

NAME (Last)		(First)	(M.I.)	**DATE OF BIRTH** **month_______ day________ year ________ Age ____**	
ADDRESS				**PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		**PHYSICIAN:**	

ETHNICITY (circle one) Hispanic or Latino Not Hispanic or Latino Unknown **SEX** (circle one) **M** **F**

RACE (circle one) American Indian or Alaska Native Black or African-American Hispanic or Latino Asian Native Hawaiian or Other Pacific Islander Other race White Unknown	**YES**	**NO**
1. Are you feeling sick today? (e.g., cold, fever, acute illness?) *Defer vaccination until after illness*		
2. Have you experienced a severe allergic reaction to any ingredient of this vaccine? (*messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose)*		
3. **Have you experienced a severe allergic reaction to any vaccine or an injectable medication? **If yes, you will need to stay 30 minutes after vaccination for observation**.		
4. In the past two weeks, have you received any vaccinations or TB skin test?		
5. I am pregnant or breastfeeding, and I have been counseled by my Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine.		
6. I have received passive antibody therapy (monoclonal antibodies or convalescent plasma) as part of COVID-19 treatment. (Moderna COVID-19 Vaccine should be deferred for at least 90 days)		
7. Have you received a COVID-19 vaccine? If yes, what brand of COVID-19 vaccine did you receive?		
8. Do you have a bleeding disorder or are you currently on a blood thinner?		
9. Are you immunocompromised or are you on medication that affects your immune system?		
10. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		

Section 2: Consent

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

The **COVID 19 vaccine is a series of two (2) injections, spaced apart based on manufacture and FDA guidelines. Please ensure that you can complete the series before consenting to this vaccine administration.**

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential in adults, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

I consent to the administration of two injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the attached Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the vaccine is a series of two injections and I intend to complete the series vaccination. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE).

Signature: ____ Date: (month ____ day ____ year 2021__)

Section 3: Permission to Release Information

My signature above gives Richland County TB & Public Health Office permission to release information regarding my vaccinations to my physician. I have been provided with Notice of Privacy Practices.

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Vaccine Manufacturer	Lot Number\ Exp Date	Name and Title of Vaccine Administrator
COVID-19	3 / / 2021	IM	R deltoid L deltoid	Pfizer	EP6955 6/30/2021	
Date billed				Procedure		Amount