Pfizer-BioNTech COVID-19 Vaccine Consent Form

Facility: _____ (The Facility)

Section 1: Personal Information (please print or affix patient sticker)

NAME (Last)	(First)	(M.I.)
DATE OF BIRTH: month_____ day_____ year _____		
PHONE NUMBER	**SEX ASSIGNED AT BIRTH M / F**	

Affix patient sticker here.

Section 2: Screening for Vaccine Eligibility	**YES**	**NO**	**N/A**
1. Have you had a severe allergic reaction after receiving a previous dose of an mRNA (Pfizer-BioNTech or Moderna) COVID-19 vaccine?	☐	☐	☐
2. Have you had an intermediate or severe allergic reaction to any ingredient in the Pfizer-BioNTech COVID-19 vaccine or to polysorbate? *Components of the Pfizer-BioNTech COVID-19 Vaccine: nucleoside-modified messenger RNA (modRNA) encoding the viral spike (S) glycoprotein of SARS-CoV-2, sodium chloride, lipids, polyethylene glycol, potassium chloride, monobasic potassium phosphate, dibasic sodium phosphate dihydrate, and sucrose*	☐	☐	
3. Are you below the minimum age requirement (5 years) for receiving the Pfizer-BioNTech COVID-19 vaccine?	☐	☐	
4. Have you received a previous COVID-19 vaccine made by a different manufacturer?	☐	☐	
5. Have you received monoclonal antibodies or convalescent plasma to treat COVID-19 in the last 90 days?	☐	☐	
6. Are you moderately or severely immunocompromised? (see details on page 2) If yes, you are eligible for a third vaccine dose, to be given at least 28 days after your second dose. You may also receive a fourth (booster) dose 6 months after your third vaccine dose.	☐	☐	
7. If you have completed a primary vaccine series with the Pfizer-BioNTech COVID-19 vaccine or the Moderna COVID-19 vaccine, do the below criteria apply to you? • 16 years of age or older for Pfizer-BioNTech COVID-19 vaccine • 18 years of age or older for Moderna COVID-19 vaccine • At least 6 months has elapsed since your second dose If yes, the Centers for Disease Control and Prevention (CDC) recommends a COVID-19 vaccine booster shot for you. Any of the currently available COVID-19 vaccines may be used for your booster dose (this consent form is for the Pfizer-BioNTech COVID-19 vaccine).	☐	☐	☐
8. If you have completed the single primary dose of the Janssen COVID-19 vaccine, do the below criteria apply to you? • 18 years of age or older • At least 2 months has elapsed since your dose If yes, the CDC recommends a COVID-19 vaccine booster shot for you. Any of the currently available COVID-19 vaccines may be used for your booster dose (this consent form is for the Pfizer-BioNTech COVID-19 vaccine).	☐	☐	☐

For the first 5 questions, if 'no' or 'N/A' answers, progress to the next section. For 'yes' answers, please seek guidance.

Section 3: Consent for Vaccination

- I have been offered and have read or had explained to me the COVID-19 Vaccine Screening Questions and Guidance.
- I also have been offered and have read or had explained to me the Fact Sheet for Patients and Parents/Caregivers for the Pfizer-BioNTech COVID-19 Vaccine that I am receiving today.
- I understand the risks and benefits of receiving the Pfizer-BioNTech COVID-19 Vaccine.
- I understand the Pfizer-BioNTech COVID-19 Vaccine is FDA approved for people 16 years of age and older. For people 5 to 15 years of age, the third dose for certain immunocompromised people, and the booster dose for certain people 16 years of age and older, the Pfizer-BioNTech COVID-19 Vaccine is available under emergency use authorization (EUA) and has not been fully reviewed and approved by the FDA.
- I understand the potential risks, including serious allergic reactions (anaphylaxis). Other reported adverse reactions include injection site pain, swelling, redness, fatigue, headache, muscle pain, chills, joint pain, fever, nausea, and swollen lymph nodes.
- I understand there may be other potential ways to prevent COVID-19.
- I was given the chance to ask questions and all questions were answered.
- I agree to receive the Pfizer-BioNTech COVID-19 Vaccine.

☐ **I GIVE CONSENT** to The Facility and its staff to vaccinate me or the person named above with the Pfizer-BioNTech COVID-19 Vaccine (the COVID Vaccine). (If you choose this option but do not sign below, then you or the person named above for whom you are giving consent will not be vaccinated).

Signature of Recipient/Healthcare Proxy _____ Date: month____day____year_____

If signing for someone other than yourself - Printed Name: _____ Relationship: _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine Manufacturer	Date Dose Administered	Lot Number	Dose	Name of Vaccine Administrator
Pfizer/BioNTech	/ /		☐ First Dose ☐ Second Dose ☐ Third Dose ☐ Booster Dose	

Section 5: Definitions

- **Moderately or severely immunocompromised**
  Your provider is best able to assess your degree of immunocompromise and optimal timing of vaccination. Moderate or severe immune compromise may be caused by immunosuppressive or immunomodulatory therapies (for example, active cancer treatment, CART-T-cell therapy, high-dose steroids) or medical conditions that affect the immune system (for example, solid-organ transplant, stem cell transplant within last 2 years, moderate or severe primary immunodeficiency, advanced or untreated HIV infection).

Section 6: Notice of Privacy Practices

- I have been offered The Facility's Notice of Privacy Practices.
- By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of Recipient/Healthcare Proxy _____ Date: month___day___year____

Section 7: Consent to Bill/Assignment of Benefits

- I will not be personally responsible for any cost or fee associated with the COVID Vaccine.
- If I am a beneficiary under any insurance or health plan or government-sponsored program (Plan/Program), I understand that the Plan/Program may be billed for the administration of the COVID Vaccine.
- I assign to The Facility any benefits under my Plan/Program for the administration of the COVID Vaccine.
- I authorize The Facility to directly bill my Plan/Program for the administration of the COVID Vaccine.
- I instruct my Plan/Program to directly pay The Facility any benefits to which I am entitled for the administration of the COVID Vaccine.
- I authorize The Facility to keep any payment received from my Plan/Program for the administration of the COVID Vaccine.

Signature of Recipient/Healthcare Proxy _____ Date: month___day___year____