COVID-19 Vaccine Consent – Pfizer 3rd Dose Booster

The COVID-19 Vaccine is administered by injection for the purpose of stimulating the production of antibodies needed for protection from the COVID-19 virus. Receiving the vaccine does not guarantee prevention of contracting the COVID-19 virus, as you may have been exposed prior to the development of adequate antibodies. This vaccine will not offer protection from becoming ill from another virus other than COVID-19. There is a possibility, as with other vaccines, that your body may not respond to the vaccine with antibody production.

I have had the opportunity to review my specific vaccine EUA fact sheet for Recipients and Caregivers and have had my questions answered. I have been provided information on reporting side effects to the Vaccine Adverse Event Reporting System (VAERS).

I acknowledge this information and consent to receiving the Pfizer COVID-19 vaccine.

	YES	NO
Have you received a second dose of Pfizer vaccine 6 months prior to today?		
Are you 65 years old or older?		
Are you 50 years old or older with an underlying medical condition?		
Are you 18 years old – 49 years old with an underlying medical condition?		
Are you 18 years old – 64 years old with an increased risk of exposure and transmission due to occupational or institutional setting?		
Do you have any allergies to any medication or a severe reaction to any vaccine or injectable therapy?		
Were you diagnosed with COVID-19 in the past 14 days?		
Do you have any COVID-19 related symptoms at this time?		
Have you ever had any serious reaction to a vaccine?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the past 90 days?		
Do you have a bleeding disorder or are you taking a blood thinner?		

Signature _____ Print Name _____ Patient/ Date of Birth _____ Date _____

Guarantor/Parent Signature _____ Print Name _____ County of Residence _____

Nurse Signature _____ Date _____

Vaccination Provider Section

Manufacturer: _____ Lot Number: _____ Expiration Date: _____

Injection site: ☐ Right Deltoid ☐ Left Deltoid

Administration time _____ Leave time _____

Patient Status: Tolerated Well ☐ No reaction ☐ Vasovagal ☐

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Complications: None ☐ Excessive pain ☐ Other ☐

Patient instructions given for reporting adverse reactions. Yes ☐ No ☐