**Covid-19 Pfizer BioNTech Vaccination**

Patient First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following will help determine if there is any reason you/your child should not receive a Covid-19 immunization. Questions should be answered for the person who will be vaccinated.

Circle One

1. Is the patient 12 years or older? YES NO
2. Has the patient ever received a Covid-19 vaccine? YES NO

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Manufacturer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the patient have a history of any immediate allergic reaction, of any severity,

after a previous does of mRNA Covid-19 vaccine or any of its components

(Including polyethylene glycol [PEG]) or polysorbate? YES NO

Cause/Allergy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the patient have a history of a severe (anaphylactic) allergic reaction to another

vaccine (other than Covid-19 vaccine) or an injectable medication? YES NO

Cause/Allergy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has the patient received passive antibody therapy for Covid-19 in the last 90 days? YES NO

I acknowledge that I have received the Emergency Use Authorization Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes Covid-19, two doses of the same vaccine may be required.

Dose #1

Patient/Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse review \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Initials

Dose #2

Patient/Parent or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse review \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Initials