



## COVID-19 VACCINE CONSENT & ADMINISTRATION FORM FOR PATIENTS

Patient Name (Print Clearly): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

HOME Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Primary Care Physician Name: \_\_\_\_\_

### VOLUNTARY CONSENT TO COVID-19 VACCINE:

I understand that COVID-19 can have serious, life-threatening complications (<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>), and there is no way to know how COVID-19 will affect me. I further understand that a COVID-19 vaccine may help keep me from becoming seriously ill, even if I do become infected with COVID-19.

I have reviewed my specific vaccine Fact Sheet or have had its contents including the benefits, the usual and most frequent risks of receiving this vaccine, and alternatives explained to me, based upon currently available information. Depending upon the COVID-19 vaccine that I receive, I may require multiple injections. I have had an opportunity to ask questions which have been answered to my satisfaction. I agree to remain at the vaccination location for at least 15 minutes after vaccine is administered in the event of adverse reaction.

I understand that:

- **COMIRNATY (Pfizer) COVID-19 Vaccine:** This vaccine is approved by the U.S. Food and Drug Administration (FDA) as a 2-dose series for use in individuals 16 years of age and older. It is also authorized under Emergency Use Authorization (EUA) issued by the FDA to provide:
  - a two-dose primary series in individuals 5 through 15 years;
  - a third primary series dose in individuals 5 years of age and older who have been determined to have certain kinds of immunocompromise;
  - a single booster dose to individuals 12 years of age and older who have completed a primary series with Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY;
  - a single booster dose to individuals 18 years of age and older who have completed primary vaccination with a different authorized COVID-19 vaccine. Booster schedule is based on the labeling information of the vaccine used for the primary series.
  - A second booster dose to individuals 50 years of age and older who have received a first booster of any authorized or approved COVID-19 vaccine and;
  - A second booster dose to individuals 12 years of age and older with certain kinds of immunocompromise and who have received a first booster of any authorized or approved COVID-19 vaccine.
- **SPIKEVAX (Moderna) COVID-19 Vaccine:** This vaccine is approved by the U.S. Food and Drug Administration (FDA) as a 2-dose series for use in individuals 18 years of age and older. It is also authorized under Emergency Use Authorization (EUA) issued by the FDA to provide:
  - a third primary series dose to individuals 18 years of age and older who have been determined to have certain kinds of immunocompromise;
  - a single booster dose to individuals 18 years of age and older who have completed a primary series with the Moderna or SPIKEVAX COVID-19 Vaccine;
  - a single booster dose to individuals 18 years of age and older who have completed primary vaccination with a different authorized or approved COVID-19 vaccine
  - a second booster dose to individuals 50 years of age and older who have received a first booster dose of any authorized or approved COVID-19 vaccine; and
  - a second booster dose to individuals 18 years of age and older with certain kinds of immunocompromise and who have received a first booster dose of any authorized or approved COVID-19 vaccine.
- Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives.
- Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.
- I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.

I understand and acknowledge record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply. I agree and authorize my COVID-19 vaccine record to be shared with my primary care physician and included in my health record(s) for continuity of care purposes. I further agree and authorize my COVID-19 vaccine record to be shared for quality of care, patient safety, and other research purposes.

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

## Reason for Today's COVID-19 Vaccine: (select ONE applicable statement)

<input type="checkbox"/> I am seeking to <b>start</b> the COVID-19 vaccine series today.
<input type="checkbox"/> I received COMIRNATY (Pfizer) or SPIKEVAX (Moderna) for my first dose and am seeking a <b>second dose</b> today.
<b>NOT Moderately or Severely Immune Compromised Patients</b>
<input type="checkbox"/> I received COMIRNATY (Pfizer) or SPIKEVAX (Moderna) for my primary two-dose series and am seeking a <b>booster</b> (3 <sup>rd</sup> dose) today. I attest that I received my second dose at least 5 months prior to today.
<input type="checkbox"/> I received J&J for my primary single dose series and am seeking a <b>booster</b> (2 <sup>nd</sup> dose) today. I attest that I received my first dose at least 2 months prior to today.
<input type="checkbox"/> I am seeking a <b>2<sup>nd</sup> booster</b> today as an individual age 50 or older. I attest that I received my first booster at least 4 months prior to today.
<b>Moderately or Severely Immune Compromised Patients</b>
<input type="checkbox"/> I received COMIRNATY (Pfizer) or SPIKEVAX (Moderna) for my primary two-dose series and am seeking a <b>third dose today</b> . I attest that I received my second mRNA dose at least 28 days prior to today.
<input type="checkbox"/> I received J&J for my primary single dose series and am seeking an <b>additional mRNA dose</b> (2 <sup>nd</sup> dose) today. I attest that I received my first dose at least 28 days prior to today.
<input type="checkbox"/> I received COMIRNATY (Pfizer) or SPIKEVAX (Moderna) for my three-dose primary series and am seeking a <b>booster</b> (4 <sup>th</sup> dose) today. I attest that I received my third dose at least 3 months prior to today.
<input type="checkbox"/> I received J&J for my primary single dose series, followed by mRNA or J&J for my additional dose, and am seeking a <b>booster</b> (3 <sup>rd</sup> dose) today. I attest that I received my second dose at least 2 months prior to today.
<input type="checkbox"/> I am seeking a <b>2<sup>nd</sup> booster</b> today as an individual age 12 or older. I attest that I received my first booster at least 4 months prior to today.

## Precautions/Contraindications: (Vaccine may not be administered depending on your responses)

Fever or feeling ill today?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer until feeling better.
History of severe allergic reaction (e.g., anaphylaxis) to any component of this vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – STOP. Do NOT vaccinate.
History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including this vaccine)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer – consult with your primary care provider.
History of severe allergic reaction (e.g., anaphylaxis) to an injectable therapy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer – consult with your primary care provider.
History of other serious allergic reaction (e.g., anaphylaxis) due to any cause	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Requires 30 min observation.
Male between 12 and 29 years of age	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Inform of risk of developing myocarditis or pericarditis after receipt of an mRNA vaccine. FMI: <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html</a>
History of myocarditis or pericarditis? <i>Myocarditis or pericarditis after receipt of the first dose of an mRNA COVID-19 vaccine series but before administration of the second dose</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer – consult with your primary care provider.
Had multisystem inflammatory syndrome; either MIS-C (children) or MIS-A (adults)	<input type="checkbox"/> No	<input type="checkbox"/> Yes – Defer – consult with your primary care provider.
Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes – revaccinate with a primary vaccine series at least 3 months (12 weeks) after transplant or CAR-T-cell therapy

Today's Date: ____/____/____	Patient Name (Print): _____
Patient / Parent / Guardian Signature; <i>if parent / guardian, please also print name</i>	
Patient DOB: ____/____/____	

-----STOP: FOR INTERNAL USE ONLY-----

Identity confirmed by:  Driver's license  Other Form of ID: \_\_\_\_\_

Vaccine Manufacturer: Lot #: Expiration Date:	Intramuscular Injection Given: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Administered By (Full name and Title):  Date of Vaccine:
<input type="checkbox"/> Pfizer VIS Given to Patient	<input type="checkbox"/> Moderna EUA Given to Patient	# dose for patient (1-5):