INTERMED
Care without compromise.

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 12 years of age and older. It is also authorized under Emergency Use Authorization (EUA) issued by the FDA to provide:
  - a three-dose primary series to individuals 6 months through 4 years of age;
  - a two-dose primary series in individuals 5 years through 11 years of age;
  - 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 5 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.**

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

Fever or feeling ill today?	☐ No	☐ Yes – Defer until feeling better.
History of severe allergic reaction (e.g., anaphylaxis) to any component of this vaccine?	☐ No	☐ Yes – STOP. Do NOT vaccinate.
History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including this vaccine)?	☐ No	☐ Yes – Defer – consult with your primary care provider.
History of severe allergic reaction (e.g., anaphylaxis) to an injectable therapy?	☐ No	☐ Yes – Defer – consult with your primary care provider.
History of other serious allergic reaction (e.g., anaphylaxis) due to any cause	☐ No	☐ Yes – Requires 30 min observation.
Male between 12 and 29 years of age	☐ No	☐ Yes – Inform of risk of developing myocarditis or pericarditis after receipt of an mRNA vaccine. FMI: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html
Had multisystem inflammatory syndrome; either MIS-C (children) or MIS-A (adults)	☐ No	☐ Yes – Defer – consult with your primary care provider.

Today's Date: _____/_____/_____	Patient Name (Print): _____
Patient / Parent / Guardian Signature; *if parent / guardian, please also print name*	
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: ☐ Left Deltoid ☐ Right Deltoid	Administered By (Full name and Title): Date of Vaccine:
☐ Pfizer VIS Given to Patient	☐ Moderna EUA Given to Patient	# dose for patient (1-5):