

Pfizer- BioNTech 2020-2021 COVID 19 VACCINE CONSENT FORM

PRINTED NAME _____ DOB _____

GENDER: _____ SOCIAL SECURITY NUMBER _____ PHONE NUMBER: _____

ADDRESS: _____ ZIP CODE: _____

 EMAIL: _____ ETHNICITY: Hispanic or Latino Non Hispanic or Latino Refuse
 RACE: African American American-Indian Asian Caucasian Pacific-Islander Unknown Refuse

INFORMATION

I understand the following treatment is planned for me: Vaccination with Pfizer-BioNTech COVID-19 Vaccine. This Pfizer-BioNTech COVID-19 Vaccine is made from a nucleoside-modified messenger RNA (modRNA) encoding the viral spike glycoprotein (S) of SARS-CoV-2. Each 0.3 ml intramuscular dose of the 2020-2021 Pfizer-BioNTech COVID-19 Vaccine contains the following ingredients: mRNA lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2hexyldecanoate), 2-[(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose. A single dose of the vaccine obtained from a multi dose vial used by Animas Surgical Hospital this year is manufactured and formulated without preservatives.

RISKS AND BENEFITS

Just as there are many risks and hazards in not taking the vaccine, I understand there are also risks and hazards related to this vaccine. I understand that no warranty or guarantee has been made to me. A vaccine, like any medicine, could possibly cause serious problems such as severe allergic reactions. Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.

If any problems occur, they usually begin soon after the shot and last 1-2 days. The most common side effects of Pfizer-BioNTech COVID-19 Vaccine are: ♦ Injection site reactions (pain, redness, swelling) ♦ Fatigue ♦ Fever ♦ Headache ♦ Muscle Pain
 ♦ Chills ♦ Joint Pain ♦ Lymphadenopathy ♦ Nausea ♦ Malaise

CONTRAINDICATIONS / PRECAUTIONS

This is a list of possible conditions to review prior to Pfizer-BioNTech COVID-19 Vaccination. If you check ✓ YES to any, please discuss with the NURSE.

- ___ Yes ___ No Life-threatening allergic reaction (e.g., anaphylaxis) to any component of the vaccine as listed above (including polyethylene glycol (PEG) and polysorbate), any other vaccine, or any injectable medication, or any food/latex/medication? If Yes, what? _____
- ___ Yes ___ No Moderate or severe acute illness with or without fever including COVID 19 in last 14 days? Delay vaccine until recover.
- ___ Yes ___ No Received any vaccinations in the last 14 days? If yes, wait 14 days until Covid 19 vaccine administration.
- ___ Yes ___ No Recovered from Covid infection in the last 3 months? Increase immune response.
- ___ Yes ___ No Had antibody therapy in the last 3 months? Defer vaccination for 90 days.
- ___ Yes ___ No Immunocompromised persons? May have a diminished immune response to the Pfizer-BioNTech Covid-19 Vaccine.
- ___ Yes ___ No Have a bleeding disorder or taking a blood thinner?
- ___ Yes ___ No Pregnant or breastfeeding? Vaccine administered to pregnant women are insufficient to inform vaccine-associate risks in pregnancy; data is not available to assess the effects of the vaccine on breastfed infant or on milk production/excretion.

I, the undersigned, hereby release Animas Surgical Hospital employees, agents, affiliates, and independent contractors from any and all liability arising from or in any way connected with receiving the Pfizer-BioNTech COVID 19 Vaccine. I have been given the current Fact Sheet For Recipients and Caregivers provided by Pfizer-BioNTech. I have read it or had it read to me and had the opportunity to ask questions. I request the 2020-2021 Pfizer-BioNTech COVID 19 vaccine be given to me.

Immunization records are confidential, personal medical information. **The Colorado Immunization Information System (CIIS)** is a lifelong immunization record tracking system under the Colorado Immunization Registry Act of 2007. I hereby consent for release of this vaccine dose to CIIS. I also give my consent for provision of this vaccine dose to other hospitals of which I am a staff member or medical staff member.

SIGNATURE _____

DATE _____

 Pfizer-BioNTech COVID 19 VACCINE Lot#: _____ Expiration Date: _____ Manufacturer: Pfizer-BioNTech
 Dose Number: _____ Dose Amount: 0.3 ml Route: IM Site: L R

NURSE SIGNATURE _____ DATE: _____ TIME: _____

Signature (must be legible)

OFFICE USE ONLY:
ED Physician on Duty Today: _____

Location: EH **Pt. Type:** OUT PT **Admit Type:** Elective **Reason:** COVID 19 Vaccine **Fin#** _____ **Registered By:** _____

 ORDERED By: _____ Date: _____ ORDER COMPLETED By: _____ Date: _____

 PREPARED By: _____ Date: _____ ADMINED By: _____ Date: _____