Pfizer 2nd Dose Clinic

COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:	*First Name:	Middle Initial:
*Date of Birth / /	*Sex: Male ☐ Female ☐ Transgendered ☐ Other ☐	
*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐		Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐
Address:		City:
State: Zip:	Home Phone:	Cell Phone:
Email:	Would like a reminder for the next appointment Yes ☐ or No ☐ postcard/call/text	
Private or employer insurance ☐	Underinsured ☐	Uninsured ☐ Medicaid ☐

HEALTH HISTORY

	YES	NO	UNKOWN
1. **Are You moderately or severely ill today?** ***(mild illnesses or taking antibiotics are not reasons to withholding vaccination)***	☐	☐	☐
2. **Do You have any allergies to foods or medications?** **If yes, please list**	☐	☐	☐
3. **Have you ever had a serious reaction after a vaccination?**	☐	☐	☐
4. **In the past 14 days have you**			
Tested Positive for COVID-19?	☐	☐	☐
Had Contact with another person with lab confirmed COVID-19?	☐	☐	☐
5. **In the past year, have you been diagnosed with COVID-19 by a medical provider?** **If yes, date of diagnosis: _____/_____/_____**	☐	☐	☐
6. **Are you breastfeeding, pregnant or planning on becoming pregnant in the next six months?**	☐	☐	☐
7. **In the past 3 months, have you taken medications that affect your immune system?** ***Such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments***	☐	☐	☐
8. **Do you currently have or a history of neurological condition, seizure or have ever had Guillain Barré Syndrome?**	☐	☐	☐
9. **In the past year, have you received a dose of COVID-19 vaccine?**	☐	☐	☐

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting http://www.hrsa.gov/cicp/.

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT		**TODAY'S DATE**
PARENT/GUARDIAN SIGNATURE	**RELATIONSHIP TO PATIENT**	**TODAY'S DATE**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of the Missouri Department of Health and
Print NAME HERE
Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

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For Clinic Use only

Manufacturer	**Brand**	**Lot number**
Dose number 1☐ or 2☐	***Exp. Date:** ___/___/___	***Date Administered:** ____/____/___
***EUA fact sheet date:** ___/___/___	***** EUA fact sheet given date:** ___/___/___	**Injection Site (Deltoid)** **L ☐ R ☐**
***Administered by Name & Title :**		
***Agency:**		
***Agency Address**		
***Clinic administration address**		