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 5 years or older? YES NO

2. Has the patient ever received a Covid-19 vaccine? YES NO
   Date: _____ Manufacturer _____

3. Does the patient have a history of any immediate allergic reaction, of any severity, after a previous dose of mRNA Covid-19 vaccine or any of its components (Including polyethylene glycol [PEG]) or polysorbate? YES NO
   Cause/Allergy _____
4. 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 _____
5. 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

Dose #3
Patient/Parent or Guardian Signature _____ Date _____

Nurse review _____ Date _____
Initials