

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 12 years or older? | YES | NO |
| 2. Has the patient ever received a Covid-19 vaccine?
Date: _____ Manufacturer _____ | YES | NO |
| 3. Does the patient have a history of any immediate allergic reaction, of any severity, after a previous does of mRNA Covid-19 vaccine or any of its components (Including polyethylene glycol [PEG]) or polysorbate?
Cause/Allergy _____ | YES | NO |
| 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?
Cause/Allergy _____ | YES | NO |
| 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