COVID-19 Pfizer Immunization Consent Form
For Ages 5- 11 years old

Patient Name: _____ Date of Birth: _____ Age: ___ Gender: Male / Female

Phone #: _____

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

Section 1: *If YES and further guidance is needed, refer to Pfizer website at www.pfizermedinfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for vaccination providers about Moderna COVID-19 vaccine refer to www.modernatx.com or call 1-866—MODERNA.	YES	NO
Have you had a previous COVID-19 vaccine? If yes, date?		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive Pfizer vaccine unless otherwise contraindicated.		
Note: A second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of your child's initial vaccine date.		

Section 2: Release and Assignment:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cdcvaccine.com: or you may also visit the LOCAL Health Unit or Springtime Pediatrics to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider (Springtime Pediatrics) for the individual named above to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in www.cdc.gov/coronavirus/vaccines.

To my insurance carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

*My signature below indicates I have read, understand and agree to **section 2. Release and Assignment** of the COVID-19 Pfizer Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).*

Signature of parent/guardian X: _____ Date: _____