COVID-19 VACCINE SCREENING AND CONSENT FORM
Pfizer COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last: First: Middle Initial:		
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian): ( )**	
Address:	**Apt/Room #:**	
City:	**State:**	**Zip:**

Sex (Gender assigned at birth)	**Race**	**Ethnicity**
☐ Female ☐ Male	☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐ White ☐ Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary Insurance Carrier _____
ID #:_____ Grp #: _____
Policy Holder's Name (if different):_____
Relationship:_____
Date of Birth_____

Which dose of Covid-19 vaccine are you requesting? (Please circle) 1st Dose 2nd Dose 3rd Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Have you had any other vaccinations in the previous 14 days?		
4. In the past two weeks, have you tested positive for COVID-19?		
5. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	**Yes**	**No**
1. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
2. Are you immunocompromised or on a medicine that affects your immune system?		
3. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
4. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 5 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Alabama Pediatrics or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 5 years of age and older; and the emergency use of this product is only

authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Alabama Pediatrics and staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Alabama's immunization registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Alabama Pediatrics or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Alabama Pediatrics or its agents with respect to the above requested items and services.
- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative_____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Vaccinator Print Name:_____ **Signature:**_____ **Date:** _____

Vaccine administering provider suffix: _____