MAXEM HEALTH URGENT CARE

PFIZER COVID-19 VACCINE CONSENT

NAME: _____ DOB: _____

I have read both the Recommendations and the Warning and side effects for Pfizer COVID-19 Vaccine, Information Sheets. I have had the opportunity to ask questions and understand the benefits, risks, and possible side effects of the COVID-19 Vaccine. I have been given the opportunity to consult with my personal physician prior to administration. I also understand that there is NO GUARANTEE that I will not contract COVID-19 or experience adverse side effects from this vaccine.

I hereby give consent for the Pfizer COVID-19 vaccine to be administered 0.5 ml (standard dose), intramuscularly to me.

MEDICAL HISTORY QUESTIONARE (PLEASE CIRCLE "YES" or "NO").

1)	Are you feeling sick today?	YES	NO
2)	Have you ever received a dose of COVID-19 vaccine? if yes, which product (Circle)? Pfizer Moderna Other: ___	YES	NO
3)	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	YES	NO
	a. Was the severe allergic reaction after receiving a COVID-19 vaccine?	YES	NO
	b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	YES	NO
4)	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
5)	Have you received another vaccine in the last 14 days?	YES	NO
6)	Have you had a positive test COVID-19 or has a doctor ever told you that you had COVID-19?	YES	NO
7)	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	YES	NO
8)	Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
9)	Are you pregnant or breastfeeding?	YES	NO

If you have any allergies, please list: _____

_____

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY:
Site of Injection (Please circle): Deltoid – Left Right Time of Injection:_____
DATE OF DOSE 1: DATE OF DOSE 2:

Administered by:_____ Location/Clinic:_____
Manufacturer: Pfizer Lot Number:_____