COVID-19 PFIZER Vaccination Consent for 12yo through Adults
Gray label (12yo and older)

GLACIAL RIDGE HEALTH SYSTEM

Last name: _____ First Name: _____ Middle Initial: _____

Home Zip Code: _____ Date of birth: _____ **Age:_____**

COVID-19 vaccination screening questions:	1. Are you sick today? (minor illness is not a contraindication to vaccination)	☐ Yes	☐ No
	2. Do you have a life-threatening allergy to any vaccine or any vaccine components? If yes, DO NOT VACCINATE. Speak with your provider.	☐ Yes	☐ No
	3. Are you pregnant or breastfeeding? (Discussion of risks and benefits with your PCP is recommended prior to vaccination. This is **not** a contraindication.)	☐ Yes	☐ No
	4. Are you immunosuppressed due to health condition or treatment? (**mark on reverse**)	☐ Yes	☐ No
	5. I am ☐Unvaccinated against COVID---Give Updated 2023-2024 COVID vaccine		
	6. I am ☐Vaccinated against COVID, but it has been **at least 2** months since **any** COVID vaccine — Give updated 2023-2024 vaccine		

INFORMED CONSENT:

I, (print name): _____, hereby acknowledge and assume the risk of COVID-19 vaccination.

I understand the COVID-19 Pfizer 2023-2024 Vaccination has received FDA Authorization for prevention of COVID-19 in persons 12 years old or older. I have had the opportunity to review the patient fact sheet for this vaccine.

I understand that there is limited information known about the safety and efficacy of using the COVID-19 vaccine. Serious and unexpected side effects may occur. Known possible side effects include:

- Allergic reactions: low blood pressure, changes in heartbeat, shortness of breath, wheezing, swelling of the lips, face, or throat, rash, nausea, vomiting, sweating, or shivering, possible during or after infusion
- Immune system reaction: fever, muscle/joint aching, myalgia, headache, fatigue, nausea/vomiting
- Pain/swelling/redness at injection site
- Swollen lymph nodes, particularly after a booster dose
- Syncope (fainting) may occur with administration of injectable vaccines, especially among adolescents.
- Very rarely: inflammation of the heart muscle or the tissues surrounding the heart

I understand the COVID-19 vaccine may cause additional risks, some of which may not currently be known at this time, in addition to the risks described above, as well as those risks for the treatment itself. I have had an opportunity to review the fact sheet on this medication. (Continue to reverse.)

❑ **YES, I consent to have the COVID-19 vaccine given to me/ my child (circle). I understand that receiving the vaccine does not preclude me/my child from wearing a mask when recommended and I/my child will continue to comply with Minnesota Department of Health regulations.**

_____ _____

Patient/ Representative Signature & Relationship to patient Date

GRAY CAP 12 AND OLDER 0.3ML

Date administered/info given: ____/____/_____		**Date of vaccine info sheet:** 9/11/2023
Lot #:	**Mfg:** **____ Pfizer Bivalent COVID-19**	**CPT Code:**
Route/Dose: **_____0.3ml IM GRAY cap (12 +)**	**IM Site:** R delt _____ L delt _____	**Name and title of vaccine administrator:** _____

9/13/23 jp

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ELIGIBILITY FOR <u>IMMUNOCOMPROMISED</u> DOSE OF COVID PFIZER VACCINE

____Currently receiving treatment for cancer

____Have had an organ transplant and are on immunosuppression therapy

____ Have had a blood stem cell transplant or CAR-T cell transplant AND

___ are within 2 years of transplant or

___ are on immunosuppression therapy

____Currently being treated with immunosuppressive medications such as

___high dose corticosteroids (<u>></u>20 mg prednisone or equivalent/day)

___alkylating agents, antimetabolites, TNF blockers, severely immunosuppressive cancer chemotherapeutic agents, transplant related immunosuppressive drugs

___other biologic agents that are immunosuppressive or immunododulatory*

____Have advanced or untreated HIV infection

____ Have a moderate or severe PRIMARY immunodeficiency (e.g. DiGeorge syndrome, Wiskott-Aldrich syndrome)

9/13/2023 jp