2024-2025 COVID-19 PFIZER Vaccination Consent for 12yo through Adults

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 OR have not received the updated 2024-2025 COVID vaccine and it has been **at least 2 months** since I received any COVID vaccine---Give 2024-2025 COVID vaccine	☐ Yes	☐ No
	6. I am 65 years old or older **and** I am moderately to severely immunocompromised **and** it has been **at least 2** months since I received the 2024-2025 COVID vaccine —Give 1 additional 2024-2025 COVID vaccine	☐ Yes	☐ No

INFORMED CONSENT:

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

I understand the COVID-19 Pfizer 2024-2025 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, chills, muscle/joint pain, headache, fatigue
- 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 particularly in the first week following vaccination. The observed risk is highest in males 12-17 years of age.

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

Pfizer Comirnaty 12 AND OLDER 0.3ML

Date administered/info given: ____/____/_____		**Date of vaccine info sheet:** 10/19/2023
Lot #: **_____ LM2219 EXP 3/29/2025** **_____ LM2215 EXP 3/15/2025** **_____ LM2221 EXP 1/4/2025**	**Mfg:** **____ Pfizer COVID-19**	**CPT Code:**
Route/Dose: **_____0.3ml IM (12 +)**	**IM Site:** R delt _____ L delt _____	**Name and title of vaccine administrator:** _____

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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 (≥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)

Verify the single dose glass prefilled syringes (including labels) prior to preparation for administration to help avoid vaccine administration errors

	2024-2025 Formula of COMIRNATY SINGLE DOSE GLASS PREFILLED SYRINGE DO NOT FREEZE
Age group	12 years and older
Verify syringe label states "2024-2025 Formula" Confirm NDC	
Dose	30 mcg
Dose volume	0.3 mL
Storage Conditions*†	
Room temperature [8°C to 25°C (46°F to 77°F)]	Must not exceed 12 hours‡
Refrigerator [2°C to 8°C (35°F to 46°F)]	Refrigerator-stable for **up to 8 months** from date of manufacture to the expiration date printed on the carton and on the syringe labels
Freezer [-25°C to -15°C (-13°F to 5°F)]	**DO NOT STORE**
Ultra-Low-Temperature (ULT) freezer [-90°C to -60°C (-130°F to -76°F)]	**DO NOT STORE**

*Regardless of storage condition, the vaccine should not be used after the expiration date printed on the glass prefilled syringes and cartons.
†Regardless of presentation, during storage, minimize exposure to room light, and avoid exposure to direct sunlight and ultraviolet light.
‡Do not shake. Remove tip cap by slowly turning the cap counterclockwise while holding the Luer lock and attach a sterile needle. Use immediately. If COMIRNATY cannot be used immediately, it must be used within 4 hours.

Important Reminder

Previous COVID-19 vaccines are no longer available for use in the United States.

FDA and CDC guidance is to check inventory and dispose of previous COVID-19 vaccines according to state and local regulations.

Confirm syringe label states "2024-2025 Formula"

GLASS PREFILLED SYRINGES
DO NOT FREEZE. If glass prefilled syringes have been frozen, discard.