

2026-2027 COVID-19 PFIZER Vaccination Consent for 5yo through Adult



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. I am unvaccinated against COVID OR it has been at least 2 months since I received any COVID vaccine.	☐ Yes	☐ No
	5. I am 65yo or older, OR I/my child have at least one underlying condition putting me/my child at risk of severe outcome from COVID. Give 2026-2027 age appropriate COVID vaccine (12yo and up—prefilled syringe)	☐ Yes	☐ NA
	6. My child aged 5-11yo has at least 1 underlying condition putting them at risk of severe outcome from COVID—give child age appropriate COVID vaccination (blue cap vial)	☐ Yes	☐ NA

INFORMED CONSENT:

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

I understand the COVID-19 Pfizer 2026-2027 Vaccination has received FDA Authorization for prevention of COVID-19 in persons 5 years old or older. I have had the opportunity to review the patient fact sheet for this vaccine.

I understand that insurance plans can vary. My insurance will be billed \$518 for COVID vaccination. I understand that I am responsible for paying any amount not covered or paid by my insurance.

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.

☐ **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 5 AND OLDER 0.3ML

Date administered/info given: ____/____/____		Date of vaccine info sheet: 1/31/2025
Lot #: RM1653__ (12yo and older) RM3739__ (12yo and older) RM4510__ (5-11YO)	Mfg: __ Pfizer COVID-19 __ Exp 6/22/27 __ EXP 6/9/27	CPT Code:
Route/Dose: ____ 0.3ml IM	IM Site: R delt _____ L delt _____	Name and title of vaccine administrator: _____

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10/5/26 jp