Vaccination Consent Form-School Pfizer
COVID-19

IF A MINOR (UNDER 19 YEARS OLD) IS NOT ACCOMPANIED BY A PARENT/GUARDIAN, THIS FORM MUST BE FILLED OUT COMPLETELY PRIOR TO MINOR ARRIVING AT CLINIC OR THEY WILL BE DENIED VACCINE.

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME

BIRTHDATE	GENDER ☐ FEMALE ☐ MALE	MOTHER'S MAIDEN NAME (First & Last)*

STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)

CITY	STATE	ZIP	PHONE #
			( ) -

*Used to verify recipient in NESIIS

1 Current Age: ☐

2 Are you feeling sick today? ☐ YES ☐ NO

3 In the last 14 days have you tested positive for COVID-19 or been exposed to a COVID-19 positive individual? ☐ YES ☐ NO

4 Have you received another vaccine in the last 14 days? ☐ YES ☐ NO

5 Have you ever received a dose of COVID-19 Vaccine? ☐ YES ☐ NO

If yes, which vaccine Product? Date received:___________

☐ Moderna ☐ Pfizer ☐ Janssen (Johnson & Johnson) ☐ Other

6 Have you had a severe reaction to a vaccine in the past? ☐ YES ☐ NO

7 Have you received COVID-19 passive antibody therapy in the last 3 months? ☐ YES ☐ NO

I understand that the vaccine being given at this clinic is **Pfizer vaccine** and will require 2 doses for it to be effective. I have been provided and have read, or had explained to me, the EUA information sheet about the COVID-19 vaccination. I understand the benefits and risks of the vaccination as described. **I have read the letter that accompanied this form stating the date and location of this clinic.** If I am not accompanying the child (recipient named above) I agree to allow the school agent named in the letter to act on my child's behalf. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent).

Signature: ***if recipient is under 19, a parent or guardian must sign consent*** **Date:**

If recipient is under 19, this section must be filled out: Emergency Contact information

Emergency Contact Name (please print): Emergency Contact Phone #:
(   )   -

ADMINISTRATIVE USE ONLY

Lot Number	Manufacturer	Site	
	Pfizer	RA	LA
		RT	LT

Nurse Signature: **Date:**

CLINIC SITE: Ain Atk Bas Blo Cha Cle Cod Cre Cro Elg Ewi Nel Nio One Orc Osm Pie Pla Spe Spr Stu Val Ver Wau
Other: ________________________

NESIIS Entry Date:	
NESIIS Entry Initials:	
VRAS:	

Revised by: HH 4-22-21