

Informed Consent for COVID-19 Vaccine (Pfizer)

_____ I verify that I have been provided with and have read the Emergency Use Authorization Fact
Initial Sheet for the Pfizer-BioNTech Covid-19 Vaccine. I acknowledge that I have had a chance to ask
questions of a medical professional about the vaccine. I understand the known risks and the
potential benefits of receiving the vaccine, as described in the Fact Sheet(s). I request and
consent to the Covid-19 Vaccine being given to me.

_____ I understand it is recommended that I remain on site for at least 15 minutes after receiving the
Initial COVID-19 Vaccine and that, depending on the recommendation of medical professionals, I may
be asked to remain on site longer for monitoring.

Signature of Vaccine Recipient Date

PRINT NAME LEGIBLY Date of Birth

_____ 1st DOSE

_____ 2nd DOSE

COVID Vaccine Manufacturer: PFIZER-BioNTech LOT# _____ Expiration _____

Injection Site: _____ Left Deltoid _____ Right Deltoid

Administered By: _____

Date/Time given: _____