

Informed Consent for COVID-19 Vaccine (Pfizer)

Initial I verify that I have been provided with and have read the Emergency Use Authorization Fact 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.

Initial I understand it is recommended that I remain on site for at least 15 minutes after receiving the 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

Address: _____

Phone No: _____ Race/Ethnicity _____

1st DOSE

2nd DOSE

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

Injection Site: _____ Left Deltoid _____ Right Deltoid

Administered By: _____

Date/Time given: _____