5-11 yrs COVID-19 Pfizer-BioNTech Vaccine Consent

Office Use Only

Injection Site: ☐ R ☐ L ☐ Deltoid ☐ Thigh

Vaccine: _____ Lot Number: _____ Patient Temp: _____

Exp. Date: _____ Date Give: _____ Administered By: _____

Patient's Full Name	Date of Birth

NEW PATIENTS & PARENTS

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Policy ID #: _____

Primary Phone: (_____) _____-_____

Insurance Carrier: _____

Policy Holder Name: _____

Policy Group #: _____

Policy Holder Date of Birth: _____

Pfizer-BioNTech COVID Vaccine: (5-11 yrs old - 2 dose Vaccine- 21 days apart

	YES	NO	I'm Not Sure
1. Are you 5-11 yrs old?	☐	☐	☐
2. Have you ever had an anaphylactic reaction to a vaccine in the past?	☐	☐	☐
3. Any allergic reaction to the ingredients in the Pfizer-BioNTech vaccine: : mRNA, lipids ((4- hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), tromethamine, tromethamine hydrochloride, sucrose, and sodium chloride.	☐	☐	☐
4. Do you currently have COVID or had a positive exposure to COVID in the last 14 days?	☐	☐	☐
5. Have you received monoclonal antibodies or convalescent plasma within the last 90 days?	☐	☐	☐
6. Do you have a temp? (We will be checking your temp prior to getting the vaccine)	☐	☐	☐

Schedule your next vaccine-- 21 days from today's visit. Please stop at the front desk to schedule.

I have read the vaccine information statement for the COVID-19 vaccine. I have no further questions related to receiving this vaccine. Signing gives Sartell Pediatrics permission to give the COVID-19 vaccine.

AUTHORIZATION TO RELASE INFORMATION: I hereby authorize this physician / clinic to release the information required in the course of my examination or treatment.
NOTICE OF PRIVACY PRACTICE: I have read and signed the consent for the use and disclosure of my protected health information. I have received a copy of the Sartell Pediatrics Notice of Privacy policy. I understand that my protected health information will be used by Sartell Pediatrics or disclosed to others for the purpose of treatment or supporting the day-to-day health care operations of the practice.
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have reviewed this consent form and give permission to Sartell Pediatrics for the use and disclosure of my protected health information.

Patient Signature: _____ Date: _____

If Minor, Parent or Guardian Signature: _____ Date: _____

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