VACCINE SCREENING AND CONSENT FORM
Pfizer-BioNTech COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Initial

Date of Birth			Age in Years	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race			Ethnicity
☐American Indian or Alaska Native	☐Native Hawaiian or Other	☐Other Asian ☐Other	☐Hispanic or Latino ☐Not Hispanic or Latino
☐Asian	☐Pacific Islander	☐Other Nonwhite	☐Unknown
☐Black or African American	☐White	☐Other Pacific Islander	

Address		
City	State	Zip Code
Cell Phone Number		
Primary Care Provider Name		Phone ( )
Insurance Carrier Name		
ID #	Group #	Policy Holder DOB:
Policy Holder Name (if different than patient)		
Social Security Number (this is needed by the federal government if you do not have health insurance)		
Driver's License #	State Issued	
Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose		

SECTION 2: COVID-19 IMMUNIZATION SCREENING QUESTIONS

Please check YES or NO for each question.	**YES**	**NO**
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past 90 days, have your received monoclonal antibodies or been diagnosed with COVID-19?		
8. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, please indicate which manufacturer's vaccine you received and date the dose was administered: ☐ Moderna COVID-19 vaccine Date administered: _____ ☐ Pfizer-BioNTech COVID-19 vaccine		
13. Did you experience a non-severe allergic reaction within 4 hours of a previous dose of COVID-19 vaccine? Non-severe allergic reactions can include: hives, swelling, redness, wheezing, GI symptoms, etc.)? If yes, please explain:		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Texas Department of State Health Services (TX DSHS) or North San Antonio Healthcare Associates or their agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary. If I experience asevere reaction, I will call 9-1-1 or go to the nearest hospital.
- I acknowledge that: (a) I understand the purposes/benefits of ImmTrac2, Texas immunization registry and (b) TX DSHS will include my personal immunization information in ImmTrac2 registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I acknowledge receipt of the Notice of Privacy Rights.
- I voluntarily elect to receive the COVID-19 vaccination at NORTH SAN ANTONIO HEALTHCARE ASSOCIATES after carefully considering the risks and benefits.
- I understand that the COVID-19 vaccinations given at NORTH SAN ANTONIO HEALTHCARE ASSOCIATES will be tracked and reported to ImmTrac, and as otherwise required by the local, state and federal government.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site*	Route	Amount Administered	Manufacturer	Lot Number	Expiration Date	Dose
RA LA	**IM**	**0.3 ml**	**Pfizer**			**1 or 2**

Administered by:	North San Antonio Healthcare Associates
Location Address:	3338 Oakwell Court, Suite 107, San Antonio, Texas 78218
Clinic Phone Number:	210-822-3646

Vaccinator (Initials)		Date		Date of EUA Fact Sheet	April 6, 2021

RA – Right Deltoid, LA – Left Arm Pfizer – 2 shot series at 0 and 21 days, authorized for 16 years of age and older.

ADDITIONAL INFORMATION If you have questions, visit the website or call the telephone number provided below. To access the most recent Fact Sheets, please scan the QR code provided below. Global website Telephone number www.cvdvaccine.com 1-877-829-2619 (1-877-VAX-CO19)