COVID VACCINE CONSENT FORM

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ________
Mother's Maiden Last: ______________________ Mother's First Name: ______________________
Date of Birth: ______________________ Gender: ______________________
Social Security: ______________________ Phone Number: ______________________ Email ______________________
Address:

If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

For children vaccines please provide answers for the child

	YES	NO	Don't Know
Are you feeling sick today?			
Have you ever received a dose of COVID-19 vaccine? - If yes, which product did you receive? Pfizer Moderna J&J			
if yes, How many doses did you receive ______________________ and on what date was the last dose? ______________________			
Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate • A previous dose of COVID-19 vaccine Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
Have you received any vaccine in the last 14 days?			
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
immunosuppressive drugs or therapies? - if yes, please specify:			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breastfeeding?			
CHILDREN ONLY			
Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?			
Did you bring your immunization record card with you? It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your			

This pharmacy may keep this record in my profile, recording what vaccine was given and when it was administered, its manufacturer, the lot and expiration, and the immunizer who administered the vaccine administered at 136 N Main St in Thiensville, Wisconsin. Your signature signs off on the following: "I have read or have had explained to me the information provided regarding the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits as well as the risks of this vaccine, and give permission to have the vaccine administered to me."

FOR CHILDREN VACCINE ONLY: I have reviewed and completed the Pre-vaccination Checklist for COVID-19 Vaccines for my child. I have received and read the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 5-11 YEARS OF AGE AND OLDER. I understand the risks and benefits, and give consent for my child to receive the Pfizer COVID-19 vaccine. I affirm that I am the parent or legal guardian of the child named at the top of this form.

I understand it is recommended that I remain on-site for at least 15 minutes after receiving the Pfizer vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on-site longer for monitoring.

Signature Patient/Legal Guardiar______________________ Date ______________________

Printed Name ______________________

harmacist Signature: ______________________ Administration Date: ______________________

Manufacturer: ☐ Pfizer ☐ Moderna Lot#:______________________ Exp Date: ______________________

AGE ☐ 6M to 4Y ☐ 5-11 ☐ Adult DL (R or L): ______________________

DOSE ☐ 1st ☐ 2nd ☐ Booster 1 ☐ Booster 2