NORTHEAST ALABAMA REGIONAL MEDICAL CENTER
PFIZER COVID-19 VACCINE CONSENT FORM

Patient Information (Please Print):

Last Name:_____ First Name: _____

Maiden Name: _____ Date of Birth: _____

Contraindications

Do not administer the Pfizer COVID-19 Vaccine to individuals with a known history of a severe allergic reaction (e.g., anaphylaxis) to any component of the Pfizer COVID-19 Vaccine *(see Full EUA Prescribing Information).*

Side Effects

The most frequent side effect is soreness around the vaccination site for up to 2 days, this occurs in less than one-third of vaccinees. In addition, the following 3 types of systemic reactions have occurred:

1. Adverse reactions reported in a clinical trial following administration of the Pfizer COVID-19 Vaccine include pain at the injection site, fatigue, headache, myalgia, arthralgia, chills, nausea/vomiting, axillary swelling/tenderness, fever, swelling at the injection site, and erythema at the injection site. *(See Full EUA Prescribing Information)*
2. Appropriate medical treatment to manage immediate allergic reactions must be immediately available in the event an acute anaphylactic reaction occurs following administration of the Pfizer COVID-19 Vaccine.
3. Guillain Barre (GBS)- This is an uncommon illness characterized by ascending paralysis, which is usually self-limited and reversible. Most people recover without residual weakness. Other neurological disorders, including encephalopathies, not defined as GBS, have been associated with vaccinations.

List of medication allergies _____

Has the patient ever received a COVID-19 vaccination? If yes, date given_____ Manufacturer_____	YES NO
Does the patient have long-term health problems with: - immunocompromised condition or taking a medicine that affects your immune system – Heart Disease –Lung Disease –Asthma –Kidney or Liver Disease –Metabolic Disease, such as Diabetes –Bleeding disorder or take a blood thinner	YES NO
Has the patient had a life threatening reaction to any injectable medication, a COVID-19 vaccine, or to a vaccine component (examples: eggs, thimerosal, gelatin, neomycin, phenol, or bovin protein)? Yes, list_____	YES NO
For Women: Are you pregnant or considering becoming pregnant in the next three months, or currently nursing?	YES NO
Has the patient had a seizure or any other brain or other nervous system problem (i.e. Guillain-Barre Syndrome after receiving a vaccine)?	YES NO

I have read the above concerning COVID-19 and the COVID-19 Vaccine. I was given the opportunity to ask questions and I understand the possible risk of the EUA Pfizer vaccine. I understand the Pfizer COVID-19 Vaccine is a vaccine and may prevent me from getting COVID-19 and there is ***no U.S. Food and Drug Administration (FDA) approved vaccine*** *to prevent COVID-19. I received the Patient Fact Sheet and I request the EUA COVID-19 vaccine be given to me. I agree not to hold NEARMC or its employees responsible for any problems I may have from receiving the Pfizer COVID-19 vaccine. I realize that the decision to take the EUA COVID-19 vaccine is totally voluntary on my part.*

_____ _____

Person receiving vaccine (**PLEASE PRINT**) Signature of Person Receiving Vaccine

(FOR CLINIC USE ONLY)

Location

RMC Employee Health & Wellness RMCA RMCS RHMC Anniston City Meeting Center

Vaccine Given: ☐ Pfizer 1st Dose ☐ Pfizer 2nd Dose ☐ Moderna 1st Dose ☐ Moderna 2nd Dose

Nurse Signature	Site of Injection LA RA	Route IM
Date		