Valleywise Health

Consent for Pfizer-BioNTech Covid-19 Immunization

Valleywise Health
2601 E. Roosevelt St.
Phoenix, AZ 85008

Office Only
ASIIS #:

First Name: _____ Last Name: _____ Phone: _____

Street Address: _____ _ City: _____ Zip Code: _____

Male □ Female □ Date of Birth: Month: _____ Day: _____ Year: _____ Age: _____

Insured for vaccines? No □ Yes □ Name of Insurance: _____ ID/SS#: _____

For patients to be vaccinated

The following questions will help us determine if there is any reason we should not give you Pfizer/BioNTech COVID-19 Vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Do you have a history of severe allergic reaction to any component of the vaccine, specifically Polyethylene glycol or PEG?
   Yes □ No □
   If yes, divert or alternately route to a physician consult.

2. Do you have a history of severe allergic reaction to another vaccine or injectable medication?
   Yes □ No □
   If yes, recommended to observe for 30 minutes

3. Do you have an immunocompromised condition?
   Yes □ No □

4. Are you pregnant or breastfeeding?
   Yes □ No □

5. If yes to question 3 or 4, have you had the opportunity to discuss decision to vaccinate with your healthcare provider?
   Yes □ No □

6. Are you ready to proceed with vaccination?
   Yes □ No □

☐ **I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine to be administered. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I understand the benefits and risks and I request that I receive the Pfizer-BioNTech Covid-19 vaccine.**

Printed name: _____ Date: _____

Patient or parent/guardian signature: _____

Staff Only:
Preferred language: _____ Interpreter services used: □

Telephonic interpreter (operator #) _____ Sight translation provided: □ Consent form read to patient: □

Vaccine Administration: Pfizer/BioNTech Covid-19 vaccine □ Site: _____
Signature: _____Date: _____
Vaccine label or lot number: _____Expiration Date: _____ NDC number: _____