PFIZER COVID-19 VACCINE PEDIATRIC CONSENT FORM ☐ PA-SiiS ☐ Pioneer

GENERAL PATIENT INFORMATION (PLEASE PRINT- MUST BE LEGIBLE)

Name: First: _____ Last: _____ Middle Initial:_____

DOB: ____/____/_____ Phone: _____

Address (REQUIRED):_____ City: _____ State: ____ Zip: _____

Sex	**Race**	**Patient's age:**	**What dose is this COVID-19 vaccination?**
☐ **Male**	☐ American Indian	☐ **5-11**	☐ **First Dose**
☐ **Female**	☐ Asian		☐ **Second Dose**
Ethnicity	☐ Black or African American	**TEMPERATURE:**	☐ **Booster (3rd Dose)**
☐ Hispanic or Latino	☐ White	_____	
☐ Not Hispanic or Latino	☐ Pacific Islander		
☐ Unknown	☐ Unknown		

INSURANCE INFORMATION

PLEASE ATTACH COPY OF INSURANCE & PARENT/LEGAL GUARDIAN'S DRIVERS LICENSE

Primary Insurance ID #: _____ RxBin: _____ RxPCN: _____ RX Group #: _____

****IF NO INSURANCE - Social Security Number (SSN): _____**

SCREENING QUESTIONS FOR PATIENT (MINOR) TO BE VACCINATED		
Please answer **YES** or **NO** to the following questions:	**YES**	**NO**
1. Are you feeling sick today?	☐	☐
2. Have you been treated with antibody therapy for COVID-19 in the past 90 days?	☐	☐
3. Have you had a serious or life-threatening allergic reaction, such as hives or difficulty breathing to *ANY* vaccine or shot?	☐	☐
4. Have you ever felt faint or dizzy during or after receiving a vaccine?	☐	☐
5. Do you have an autoimmune disease or any condition that weakens the immune system?	☐	☐

✓ 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 5 years of age**; or (c) authorized to consent for vaccination for the patient named above. Furthermore, I hereby give my consent to Rann Pharmacy or its associates to administer the COVID-19 vaccine.

✓ I understand that *Pfizer*-BioNTech COVID-19 Vaccine is a vaccine that may prevent COVID-19. This vaccine has been authorized by the FDA for emergency use to prevent COVID-19 in individuals 5 years of age and older under a Emergency Use Authorization (EUA).

✓ I understand that *Pfizer*-BioNTech COVID-19 Vaccine is not recommended to be administered to individuals with known history of a severe allergic reaction to any component of the *Pfizer*-BioNTech COVID-19 Vaccine. The active components are: mRNA (BNT162b2 RNA), polyethylene glycol (ALC-0159), sodium chloride, sucrose, potassium chloride, potassium phosphate, sodium phosphate. I attest that I, or the patient listed above, have not had any severe allergic reactions to the components listed above.

✓ 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 that 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 understand that the *Pfizer*-BioNTech COVID-19 Vaccine may not fully protect all those who receive it and no guarantees or promises have been made to me concerning the effectiveness of this vaccine.

✓ I understand that side effects following the *Pfizer*-BioNTech COVID-19 Vaccine may include:

- o Injection site pain, swelling or redness
- o Tiredness
- o Headache
- o Muscle or joint pain
- o Chills
- o Fever
- o Nausea
- o Enlarged lymph nodes

✓ I acknowledge that the patient/guardian has been advised to remain near the vaccination location for **approximately 15 minutes** (or more, in specific cases) after administration for observation, as instructed. If the patient experiences a severe reaction, I will call 9-1-1 or seek emergency medical help immediately.

✓ On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Rann Pharmacy and their staffs, agents, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

✓ I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania's immunization registry (PA-SIIS) and (b) Rann Pharmacy will include my/my child's immunization information in the PA-SIIS and this information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

✓ I understand there is no out of pocket cost to the patient for the COVID vaccine or its administration. If I have insurance, I give permission for my insurance to be billed and if I do not have insurance, I agree to have the uninsured program billed to cover the cost of the services provided.

✓ I acknowledge the receipt of the Notice of Privacy Rights.

✓ I hereby CONSENT to the *Pfizer*-BioNTech COVID-19 Vaccine and authorize Rann Pharmacy representatives to administer the vaccine to me or my child.

Vaccine Recipient Name (Printed): _____

Vaccine Recipient Signature (Only if >18): _____

IF SIGNING ON BEHALF OF THE VACCINE RECIPIENT, I ATTEST THAT I AM THE PATIENT'S PARENT/LEGAL GUARDIAN

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ Date: _____

FOR VACCINATOR ONLY:

Vaccine Name	*Manufacturer*	*LOT*	*EXP. DATE*	*Dosage*	*Site*	*Date of EUA*
COVID19-PFR-P	*Pfizer*			0.2 ml	RIGHT Deltoid LEFT Deltoid	5/17/2022

Vaccinator Name: _____ Signature: _____ Date: ___/___/____