Pfizer COVID-19 Vaccine Consent Form

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Race: ☐White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused	Hispanic Ethnicity: ☐ Yes ☐ No ☐ Unknown ☐ Refused

I declare that I am 18 years of age or older.

1. I understand that the Pfizer-BioNTech COVID-19 Vaccine is a vaccine that may prevent COVID-19 infection. This vaccine is currently FDA-approved for certain ages and has been authorized by the FDA for emergency use to prevent COVID-19 in other age groups under an Emergency Use Authorization (EUA).
2. 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.
3. I understand that it is not recommended that an individual get the Pfizer-BioNTech COVID-19 Vaccine if the individual has had a severe allergic reaction after a previous dose of this vaccine. I, nor my child, have not had a severe allergic reaction to a previous dose of the Pfizer-BioNTech COVID-19 Vaccine.
4. I understand that signs of an allergic reaction may include rash, shortness of breath, and swelling of the face, lips, tongue. or throat. I understand that if I experience any of these symptoms, I should contact my healthcare provider or seek emergency medical help right away.
5. I understand that I/my child will be required to wait, as instructed, after the vaccination for observation.
6. I understand that the Pfizer-BioNTech COVID-19 Vaccine is a vaccine series comprising of more than one injection and booster doses may be needed in the future. I understand and agree that I, or my child, will receive the vaccine series and booster dose(s) when the allotted time has passed.
7. I understand that I need to notify the vaccination site staff PRIOR to getting vaccinated if I am feeling sick, was exposed to a confirmed COVID patient, am currently in quarantine for COVID exposure, or if I have tested positive for COVID in the past 14 days.
8. I understand that I need to notify the vaccination site staff PRIOR to vaccination if I have previously received any other COVID vaccines such as Moderna or Johnson & Johnson COVID vaccines.
9. I understand that immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a weakened immune response to the Pfizer-BioNTech COVID-19 Vaccine.
10. I understand that 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.
11. I understand that side effects following the Pfizer-BioNTech COVID-19 Vaccine include but are not limited to:
    - injection site pain
    - tiredness
    - headache
    - muscle pain
    - chills
    - joint pain
    - fever
    - injection site swelling
    - injection site redness
    - nausea
    - general feeling of feeling unwell
    - enlarged lymph nodes
12. I understand that severe allergic reactions have been reported following the Pfizer-BioNTech COVID-19 Vaccine.
13. I understand that there may be other risks or complications that are not yet known and may only become known as more people obtain the Pfizer-BioNTech COVID-19 Vaccine.
14. I understand that there is currently limited data available on the use of this vaccine in pregnant or breast-feeding women. If I am, or my child is, pregnant, breast-feeding, or may become pregnant, I should ask my doctor, or my child's doctor, for advice before receiving this vaccine.
15. I understand that Ashley Pediatrics Day & Night Clinic or Industrial Health Works, as the vaccination provider, must include my, or my child's, vaccination information in the state/local jurisdiction's Immunization Information System (IIS)

or other designated system. I understand Ashley Pediatrics Day & Night Clinic or Industrial Health Works is responsible for sharing data related to the COVID-19 vaccinations, including the FDA, Centers for Disease Control (CDC), and other state and federal agencies, and such data sharing may include all personal information I have provided about myself and/or my child to Ashley Pediatrics Day & Night Clinic or Industrial Health Works for purposes of receiving this vaccine, errors, adverse events, cases of MIS in adults and children, and cases of COVID-19 that result in hospitalization or death following administration of Pfizer-BioNTech COVID-19 Vaccine to recipients.

16. 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.

RELEASE OF LIABILITY: I have read and understand the acknowledgements above, and I hereby release Ashley Pediatrics Day & Night Clinic or Industrial Health Works, and all of their agents, employees, trustees, and representatives, 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.

CONSENT TO THE VACCINATION: I have been given access to and read or have had read to me the Pfizer-BioNTech COVID-19 Vaccine fact sheet for the vaccine I or my child will receive. I understand all risks as outlined in that fact sheet. I have been given the opportunity to ask questions about the Pfizer-BioNTech COVID-19 Vaccine and have had all questions answered to my satisfaction. I have been given access to the Notice of Privacy Practices ("Notice"). The Notice explains how Ashley Pediatrics Day & Night Clinic or Industrial Health Works may use and disclose the patient's Protected Health Information for treatment. "Protected Health Information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact the Privacy Office at (956) 259-0400. **Both the fact sheet and the privacy notice can be found at ashleypediatrics.com.**

I hereby CONSENT to the Pfizer-BioNTech COVID-19 Vaccine and authorize Ashley Pediatrics Day & Night Clinic or Industrial Health Works representatives to administer the Pfizer-BioNTech COVID-19 Vaccine and subsequent COVID-19 vaccines to me or my child.

Vaccine Recipient Name (Printed): _____

Vaccine Recipient Signature (Only if not a minor): _____

Pediatric Patients: If signing on behalf of the Pediatric Vaccine Recipient, I attest that I am the Patient's Parent/Legal Guardian.

Parent/Legal Guardian Name (Printed): _____

Parent/Legal Guardian Signature: _____ Date: _____

For Office Use Only:

<table>
<tr><td colspan="2">Manufacturer: ☐ Pfizer: 6mo-4yr / 5-11yr / 12+yr</td><td>Route: Intramuscular</td><td>Lot #</td></tr>
<tr><td colspan="2">Primary Series Dose #____
Booster #_____</td><td colspan="2">*Exp. Date: ___ /___ /___</td><td>*Date Administered:
____ /____ /____</td></tr>
<tr><td>Vaccine Dose:
☐ 12+yr Pfizer 0.3 ml
☐ 5-11yr Pedi Pfizer 0.2 ml
☐ 6mo-4yr Pedi Pfizer 0.2 ml</td><td colspan="2">Vaccine Administration Clinic:
☐ Ashley Pediatrics
☐ Industrial Health Works</td><td>Injection Site (Deltoid): ☐ L ☐ R
Administered by:</td></tr>
</table>

TEXAS Health and Human Services | Texas Department of State Health Services

ImmTrac2 Immunization Registry
DISASTER INFORMATION RETENTION CONSENT FORM

(Please print clearly)

Client's Last Name

Client's First Name

Client's Middle Name

Client's Date of Birth (__/__/____)

*A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Client's Gender: ☐ Male ☐ Female

Client's Address

Apartment #

Client's Telephone (___-___-____)

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, has been designated as the disaster-related reporting and tracking system for immunizations, antivirals, and other medications administered to individuals in preparation for, or in response to, a disaster or public health emergency. From the time the event is declared over, ImmTrac2 will retain disaster-related information received from health-care providers for a period of 5 years. At the end of the 5 year retention period, client-specific disaster-related information will be removed from the Registry unless consent is granted to retain the client information in ImmTrac2 beyond the 5 year retention period.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period. I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, my (or my child's) disaster-related information may by law be accessed by:

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and / or
- a physician or other health-care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent to retain my disaster-related information (or my child's information if younger than age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or parent, legal guardian, or managing conservator): _____

Printed Name:

Date:_____ Signature: _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.texas.gov for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac2 DC

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and **affirm** that consent has been granted.

DO NOT fax to ImmTrac2. **Retain this form in your client's record.**

Ashley Pediatrics
Day and Night Clinic

Industrial Health Works
OCCUPATIONAL & FAMILY MEDICINE CLINIC

COVID-19 PATIENT QUESTIONNAIRE

1. Have you developed any of these symptoms recently? Mark all that apply.

Notify staff immediately!

- ☐ Shortness of breath or difficulty breathing
- ☐ Chest Pain
- ☐ Fever
- ☐ Chills
- ☐ Cough
- ☐ Fatigue
- ☐ Muscle weakness or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

☐ New ☐ Established

Insurance & Member ID

_____

Reason for Visit

_____

Car Color & Make

_____

Medication Allergies

_____

Primary Care Doctor

_____

☐ YES ☐ NO 2. Have you been exposed to a COVID-19 suspected or infected person?

☐ YES ☐ NO 3. Are you fully vaccinated against COVID-19?

If yes, when? _____ Which vaccine? _____

☐ YES ☐ NO 4. Have you ever tested positive for COVID-19? If yes, when? _____

☐ YES ☐ NO 5. Have you had any family or friends visit or have you visited any family or friends recently?

☐ YES ☐ NO 6. If you visited family or friends, did everyone "social distance" and wear a face mask?

Patient Name _____ Date of Birth _____

Home Address _____

Phone _____ Alternate Phone _____

Emergency Contact & Phone _____

Preferred Pharmacy & Phone _____

I, the undersigned, certify that I have given true, accurate, and complete information on this questionnaire to the best of my knowledge.

Questions asked by (initial): _____

Patient/Guardian Signature _____ Date _____