CCM Health

SCREENING FOR
PFIZER-BIONTECH COVID-19 VACCINE

Name: _____ Date of Birth: _____ Employee ID: _____

SCREENING:

Please respond to each of the following statements:

☐ YES ☐ NO Have you had a previous allergic reaction to a vaccine?

☐ YES ☐ NO Are you currently ill?

☐ YES ☐ NO Do you have any immunocompromising conditions?

☐ YES ☐ NO Are you pregnant or lactating?

If you marked **Yes** to any of the items above, you must provide documentation from your health care provider stating you are able to receive the COVID Vaccination.

Signature of Recipient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

D: 12/2020

CONSENT FOR
PFIZER-BIONTECH COVID-19 VACCINE

I have been offered the Pfizer-BioNTech COVID-19 Vaccine.

- I recognize that the vaccine is experimental and has been authorized for emergency use only by the FDA. It is not an FDA-approved vaccine.
- I am aware that I have a right to decline to receive this vaccine.
- I have had the opportunity to review the "Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients". (www.cvdvaccine.com)
- I am aware that there is no guarantee that administration of the vaccine will prevent my becoming infected with the COVID-19 virus. I understand that to be effective a second dose is required.
- I acknowledge that there are risks and potential side effects from the vaccine some of which are unknown. Among the reported side effects of the vaccine are:

  - Injection site pain
  - tiredness
  - headache
  - muscle pain
  - chills
  - joint pain
  - fever
  - injection site swelling
  - injection site redness
  - nausea
  - feeling unwell
  - swollen lymph nodes (lymphadenopathy)

- I understand that I may have an allergic reaction to the vaccine.
- I understand that, at this time, there are no available alternative vaccines.
- I understand that I may consult a physician of my own choosing for advice on receiving the vaccine.

I have read this consent form and have been provided the "Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients".

❑ **YES**, I wish to receive the Pfizer-BioNTech COVID-19 Vaccine.

❑ **NO,** I do not wish to receive the Pfizer-BioNTech COVID-19 Vaccine.

Signature of Recipient: _____ Date: _____

Signature of Parent/Guardian:_____Date:_____

COVID-19 Vaccine 0.3 mL given IM in RIGHT or LEFT deltoid on __ /__ /___ Vaccine Dose# 1 OR 2

Administered By: _____ Title: _____ Employee ID#: _____

Brand & Lot Number of Vaccine Administered

BRAND	LOT NUMBER	EXPIRATION DATE
□ **Pfizer**		
□		
□		