St. Bernards MEDICAL CENTER
The Heart of Great Medicine

Pfizer-BioNTech COVID Vaccine Consent Form

PLEASE PRINT LEGIBLY

Legal Name: _____

Lawson ID#_____ **(St. Bernards Employees)**

St. Bernards Department or Employer:

_____

Position: _____

This is my:

FIRST DOSE ☐ **SECOND DOSE** ☐

OF COVID VACCINE

(CIRCLE ONE)

1. When receiving vaccines in the past, have you ever experienced any problems?

YES* ☐ NO ☐

*If yes, what kind of problems?

2. Have you received any vaccination within the last 2 weeks? Yes ☐ NO ☐

3. Do you have another vaccination scheduled? (Other than this COVID vaccine series)

YES ☐ NO ☐

4. Have you received COVID 19 treatment with monoclonal antibodies or convalescent plasma within the last 90 days?

YES ☐ NO ☐

5. Do you have any allergies or reactions to any foods, medications, or vaccines?

YES ☐ NO ☐

6. Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?

YES ☐ NO ☐

7. For females, are you pregnant, planning to become pregnant or breastfeeding? YES ☐ NO ☐ Not Applicable ☐

8. Do you have a bleeding disorder or are you on a blood thinner? YES ☐ NO ☐

9. Have you received a COVID-19 vaccine other than the initial Pfizer-BioNTech if this is your second dose?

YES ☐ NO ☐

10. Are you immunocompromised or are you on a medicine that affects your immune system?

YES ☐ NO ☐

(OVER)

REV 3/22/2021

CONSENT FOR VACCINATION:

I have been provided with the most current Fact Sheet for Recipients and Caregivers for the Emergency Use Authorization of the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) that explains the benefits and risks of receiving vaccination. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine. I understand that if I receive one dose of the Pfizer-BioNTech COVID-19 Vaccine, I should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

I request that the vaccine be given to me.

Legal Name:

_____

(Printed)

Male: _____ Female: _____

Date of Birth: _____

(Month/Day/Year)

Race: _____

Hispanic _____Not Hispanic/Latino_____

Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Phone: (_____) _____-_____

By providing St. Bernards with your phone number, you consent to St. Bernards or its agents contacting you via text message or phone call regarding your vaccines and/or vaccine appointments.

Signature: _____

Date: _____

Time: _____

HOSPITAL USE ONLY

Manufacturer: Pfizer-BioNTech

Lot#: _____

Exp. Date: _____

IM Injection Site: **R deltoid** ___

L deltoid ___

Dose: 0.3 ml

_____

Administering Provider Signature/Credential

Date: _____

Time: _____

Parent/Legal Guardian Signature (required if under 18) _____

Relationship to patient_____