

**Pfizer-BioNTech COVID-19 Vaccination Consent under Emergency Use Authorization (EUA)**

Patient Demographic Information					
Last Name:		First Name:		Middle Initial:	
Date of Birth:     /     /			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Refused <input type="checkbox"/> Unknown			Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused		
Address:			City:		County:
State:	Zip:	Home Phone:		Cell Phone:	
Email:					
Insurance Type: <input type="checkbox"/> Private/Commercial <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid					

Health History	Yes	No
1. Are you sick today?		
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or an Epi-Pen or for which you had to go to the hospital?		
3. Have you ever had a serious reaction after any vaccination or injectable medication including a previous dose of the COVID-19 vaccine?		
4. In the past 14 days have you had contact with a confirmed COVID-19 patient?		
5. Are you breastfeeding or pregnant?		
6. Have you received passive antibody therapy as a treatment for COVID-19?		
7. Are you immunocompromised? (Taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)		
8. Do you have a bleeding disorder or are you taking a blood thinner?		
9. Have you ever received a dose of COVID-19 vaccine?		

Vaccine Priority Designation	
By checking the box(es) below, I certify that I am in the following Vaccine Priority Group(s):	
<input type="checkbox"/>	Age 65 or older
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Chronic Kidney Disease
<input type="checkbox"/>	Chronic Obstructive Pulmonary Disease (COPD)
<input type="checkbox"/>	Heart Conditions such as Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) or cardiomyopathies
<input type="checkbox"/>	Immunocompromised state from organ transplant
<input type="checkbox"/>	Intellectual and/or developmental disabilities such as Down syndrome
<input type="checkbox"/>	Severe Obesity (BMI >40kg/m2)
<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Type 1 or Type 2 Diabetes Mellitus

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<b>Consent</b>
The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting <a href="https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine">https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine</a>

Signature of Patient:	Date:        /        /
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<b>Administration – Clinic Use Only</b>		
Manufacturer: Pfizer	Brand: Pfizer-BioNTech COVID-19 Vaccine	Lot Number:
Dose Number: <input type="checkbox"/> 1 <input type="checkbox"/> 2	Exp Date: 05/2021	Date Administered:        /        /
EUA Fact Sheet Date: 12/2020	Injection Site (Deltoid): <input type="checkbox"/> Left <input type="checkbox"/> Right	EUA Fact Sheet Given:        /        /
Administered By:		Agency: Jefferson City Medical Group
Agency Address: Jefferson City Medical Group, 1241 West Stadium Blvd., Jefferson City, MO 65109		
Clinic Admin Address: Jefferson City Medical Group, 1241 West Stadium Blvd., Jefferson City, MO 65109		