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

Patient Demographic Information			
Last Name:	First Name:		Middle Initial:
Date of Birth: / /	Gender: ☐ Male ☐ Female ☐ Transgendered		
Race: ☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaska Native ☐ Refused ☐ Unknown		Hispanic Ethnicity: ☐ Yes ☐ No ☐ Refused	
Address:	City:		County:
State:	Zip:	Home Phone:	Cell Phone:
Email:			
Insurance Type: ☐ Private/Commercial ☐ Uninsured ☐ 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):	
☐	Age 65 or older
☐	Cancer
☐	Chronic Kidney Disease
☐	Chronic Obstructive Pulmonary Disease (COPD)
☐	Heart Conditions such as Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) or cardiomyopathies
☐	Immunocompromised state from organ transplant
☐	Intellectual and/or developmental disabilities such as Down syndrome
☐	Severe Obesity (BMI >40kg/m2)
☐	Pregnancy
☐	Sickle Cell Disease
☐	Type 1 or Type 2 Diabetes Mellitus

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Consent
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 https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine

Signature of Patient:	Date: / /

Administration – Clinic Use Only			
Manufacturer: Pfizer	Brand: Pfizer-BioNTech COVID-19 Vaccine		Lot Number: EL3247
Dose Number: ☐ 1 ☐ 2	Exp Date: 05/2021	Date Administered: / /	
EUA Fact Sheet Date: 12/2020	Injection Site (Deltoid): ☐ Left ☐ 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			