COVID-19 Pfizer-BioNTech Vaccination

PLEASE PRINT

Patient *FIRST* Name: **_LAST_ Name:** **MI:**

Maiden Name (Optional):

DOB: / / **Current Age:** **Sex:** ☐ F ☐ M ☐ Other

Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown

Address: **City:** **State:** **Zip:**

Cell Phone: ( ) **Alternate Phone:** ( )

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. Questions should be answered for the person who will be vaccinated.
If a question is not clear, please ask a healthcare provider to explain.

1.	Younger than 16 years old?	☐ Yes	☐ No
2.	History of any immediate allergic reaction, of any severity, after a previous dose of mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG]) or polysorbate?	☐ Yes	☐ No
	Cause/Allergy: _____		
3.	History of immediate allergic reaction of any severity to any substance?	☐ Yes	☐ No
	Cause/Allergy: _____		
4.	Ever received a COVID-19 vaccine?	☐ Yes	☐ No
	Date: _____ **Manufacturer:** _____		
5.	Sick today, including symptomatic/asymptomatic infection with COVID-19?	☐ Yes	☐ No
6.	Received passive antibody therapy for COVID-19 in the last 90 days?	☐ Yes	☐ No
7.	Received any vaccine in the past 14 days?	☐ Yes	☐ No
8.	Pregnant or breastfeeding?	☐ Yes	☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and the Tennessee Department of Health's Notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ **DATE:** _____

This consent is valid for 12 months from date signed.