COVID-19 BOOSTER VACCINATION CONSENT FORM

Pfizer-BioNTech COVID-19 Vaccine

PLEASE PRINT CLEARLY

_____ _____

Last Name First Name

_____ _____ _____ _____

Street City State Zip

_____ _____ _____

Telephone Number Date of Birth Gender

Ethnicity: ◯ Hispanic ◯ Not Hispanic ◯ Unknown

Race: ◯ White ◯ Black or African American ◯ American Indian ◯ Asian ◯ Other

Parent or Legal Guardian Name: _____ Phone Number: _____

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Grayson County Health Department to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain at the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the Grayson County Health Department, and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Texas's immunization registry and my personal immunization information will be shared with the Centers for Disease Control (CDC), local, state, and/or other federal agencies, or medical providers.
- I have received the office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed, in addition to the acknowledgment directly above this statement. I understand that I am entitled to receive a copy of this document. THIS DOCUMENT IS AVAILABLE UPON REQUEST.

MEDICAL SCREENING QUESTIONS: Check yes or no to each question below.

Questions	Yes	No
Do you have any allergies?		
Are you feeling sick today or do you have a fever?		
Do you have a bleeding disorder or are on a blood thinner?		
Have you had a severe allergic reaction after a previous dose of this vaccine?		
Has it been at least 6 months since your 2nd dose of the Pfizer COVID-19 vaccine?		
Are you or is the individual receiving the vaccine 16 years of age or older?		

I attest that the contents of this COVID-19 Booster Vaccination Consent Form are true and correct.

_____ _____

Signature of Recipient OR Recipients Authorized Individual (parent or legal guardian) Date

_____

Print Name of Representative and Relationship to the person receiving the vaccine

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DO NOT WRITE IN THIS SPACE – OFFICE USE ONLY

Manufacture: Pfizer-BioNTech

Administration Date: _____

Lot #: _____ Expiration Date: _____

Site (circle one): RIGHT LEFT

_____ _____

Nurse/Provider's Signature Date