

COVID-19 Vaccine Administration Record Pfizer Parental Consent



Section 1: Vaccine Recipient Information

Recipient name: _____
Last name First name M.I.

Address: _____
Street City State ZIP

Date of birth: _____ Age: _____ Gender: Male Female

Section 2: Screening for Vaccine Eligibility

Has the person listed above previously received COVID-19 vaccine? Yes No

If yes to above, indicate the COVID-19 vaccine previously received: _____

Section 3: Screening Questionnaire

Are you feeling sick today? YES NO

Have you been treated with antibody therapy for COVID-19 in the past 90 days? YES NO

Have you had a serious or life-threatening allergic reaction, such as hives, or difficulty breathing to *any* vaccine or shot? YES NO

Have you had any vaccines in the past 14 days? (Including flu shot) YES NO

Are you pregnant, considering becoming pregnant or breast feeding? YES NO

Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system? YES NO

Do you take any medications that affect your immune system such as steroids, anticancer drugs or have you had any radiation treatments? YES NO

Section 4: Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. I understand that this is a 2 part vaccine and I will need to receive the 2nd dose in 21 days for the vaccine to be fully effective.

Signature: _____ Date: _____

Healthcare Provider Use Only

Date Vaccine Administered: _____ Injection Site (Deltoid): Left Right

Manufacturer: _____ Lot number: _____ Exp: _____

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____