RIVERSIDE HEALTH SYSTEM 2021

Regional Community Vaccine Clinic

COVID-19 Vaccination Consent Form - Manufacturer: Pfizer

Part A: Patient to complete and sign at "X" below

Full Legal Name ______________________________

Date of Birth ____________________ **Gender** ____________

Address ______________________________

____

Phone Number ______________________________

Email ______________________________

Please check appropriate box:

	Yes	No
1. Have you had a severe (life-threatening) allergic reaction to any vaccine or injectable medication?		
2. Do you have a fever or other symptoms of acute illness?		
3. Have you received any other vaccine within the last 14 days?		
4. Have you received COVID-10 monoclonal antibody or convalescent plasma in the last 90 days?		
5. Are you allergic to latex?		

I have been provided and read the COVID-19 vaccine Fact Sheet for Receipients and Caregivers.
I have had a chance to ask questions which were answered to my satisfaction.

I understand the benefits and risks of COVID-19 vaccine and request that the COVID-19 vaccine be given to me or to the person for whom I am authorized to make this request.

X ______________________________ Date ____________

Signature of person receiving COVID-19 vaccine
or person authorized to make the request if person receiving COVID-19 vaccine is a minor

Part B : To be completed by RHS Covid-19 Vaccination Team

Given: [X] Pfizer COVID-19 Vaccine 0.3 ml IM

Site/Deltoid: [ ] Right [ ] Left

Administered By (Name & Credentials): ______________________________