Pfizer COVID-19 Booster Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine

NAME (Last)	(First)	(M.I.)	**Date of Birth** **Month_____Day_____Year_____**
Height	**Weight**	**Age**	**Gender**
Drug Allergies			
Pfizer: 1st Dose Date ________ 2nd Dose Date ________ Location:_____________ **Vaccine card presented ☐ Yes or ☐ No Immtrac Verified: ☐ Yes or ☐ No**			

Must Be 6 MONTHS since 2nd Dose of Pfizer:

Must meet one of the following Criteria:

Recommended for:

- ☐ 65 Years of Age or Older
- ☐ 50-64 Years of Age or older with underlying health issues
  - Cancer, Chronic Kidney disease, chronic lung disease (COPD, Asthma (Mod to severe), Interstitial lung disease, cystic fibrosis, and pulmonary hypertension), Dementia, Neurological conditions, Down syndrome, Diabetes(type 1 or type 2), Heart Condition, HIV infection, Pregnancy, Sickle cell disease, Thalassemia, Smoking(current or former) Organ Transplant, Stem cell transplant, Stroke, Cerebrovascular disease.
- ☐ 18 Years of Age or Older living in a long-term care facility

May Receive:

- ☐ 18-49 Years of Age with underlying health issues
  - Cancer, Chronic Kidney disease, chronic lung disease (COPD, Asthma (Mod to severe), Interstitial lung disease, cystic fibrosis, and pulmonary hypertension), Dementia, Neurological conditions, Down syndrome, Diabetes(type 1 or type 2), Heart Condition, HIV infection, Pregnancy, Sickle cell disease, Thalassemia, Smoking(current or former) Organ Transplant, Stem cell transplant, Stroke, Cerebrovascular disease.
- ☐ 18-64 Years of Age with Increased risk for COVID-19 exposure and transmission
  - Workers in the following fields: First Responders, Firefighters, Police, Healthcare, Education, Food and agriculture, Manufacturing, Corrections, U.S. Postal Service, Public transit, Grocery Store.

Section 2: Consent

I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I understand the benefits and risks of the vaccination and I voluntarily assume full responsibility for any reactions that may result.

______________________________________ ________________________
Patient/Representative Signature Date

______________________________________ ________________________
Name of Representative Relationship

Account # _________________

Section 4: Vaccination Record

Date of Vaccination	**Site of Injection (please circle)**		**Vaccine Manufacturer**	**Lot Number**	**Expiration Date**	**Name and Title of Vaccine Administrator**
	L arm	R arm				