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PEDIATRIC ASSOCIATES OF SAVANNAH

912.355.2462

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Pfizer-BioNTech COVID-19 Vaccine Consent Form

Name of Recipient (Last, First): _____,_____

Date of Birth: _____ Sex: _____ Age_____ Phone:_____

Check the appropriate box:

Yes ☐ **No** ☐ Recipient HAS experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
- If YES, notify our staff immediately before the vaccine is administered as the patient will require 30 minutes of observation

I declare that I or my child is 16 years of age or older. I further declare that I or my child:

1. Have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
2. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
3. Has have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
4. Is not allergic to the following ingredients in the COVID-19 vaccine: mRNA, lipids((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2[(polyethylene glycol)-2000]-N, N-ditetradecylacetamide, 1, 2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate and sucrose.

I understand that if I or my child have any of the above conditions, I or my child could be at increased risk of having a negative reaction or problem from the vaccine. I further declare that if I or my child have any of the conditions listed directly below, I have had the opportunity to speak with my or my child's primary care provider and am making an informed decision to receive the vaccine or to have my child receive the vaccine:

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I agree to WAIT in the clinic location for 15 minutes after receiving the vaccine. If I or my child have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT in the clinic location for 30 minutes after receiving the vaccine.

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I or my child will receive the first and second part of the vaccine series as scheduled.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Pediatric Associates of Savannah, PC. The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of Pediatric Associates of Savannah, PC giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless Pediatric Associates of Savannah, PC, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. Pediatric Associates of Savannah, PC makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness. I acknowledge receipt of Pediatric Associates of Savannah, PC Notice of Privacy Practices.

I have read and understood "What To Do If You Have A Reaction To The COVID-19 Vaccination" and the "Fact Sheet for Recipients and Caregivers" by the FDA regarding the COVID-19 Vaccination. I further understand and agree that Pediatric Associates of Savannah, PC is required to submit COVID-19 vaccine administration data to the Georgia Registry of Immunization Transactions & Service (GRITS) and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of Pediatric Associates of Savannah, PC to give me or my child a COVID-19 vaccine.

Signature of Guardian/Patient (if over 18):_____ **Date:** _____

Return this form to the nurse once signed. Do not write below (Office Use Only)

Check In Info:	Injection Admin Info	Data Entry Info	Reaction Mon. Info:
Insurance:_____ FDA Fact Sheet Given: ☐ 21 day 2nd Dose Appt Date/Time:_____ Staff Name/Initials:_____	Lot# _____ Exp. Date _____ Route: ☐ IM R Deltoid ☐ IM L Deltoid Other:_____ Injection Date/Time: _____ Staff Name/Initials:_____	☐ CDC Card Given/Updated ☐ Entered in eCW ☐ Entered in GRITS Staff Name/Initials:_____	Monitoring Time: 15min 30min (Circle one) Reaction: Yes No (Circle one) Time Discharged: _____ Staff Name/Initials:_____

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IMPORTANT: Do not leave the office without an **updated COVID-19 vaccine card AND** (if applicable) appointment information for the **second injection**

Pfizer-BioNTech COVID-19 Vaccine Consent Form

Information about the COVID-19 Vaccine

- **You must review the FDA's "Fact Sheet for Recipients and Caregivers"online at www.cvdvaccine.com or via the QR code above.**
- **The COVID-19 vaccines are not live virus vaccines so the vaccines cannot infect anyone with COVID-19.:**
- **All needles and syringes are sterile, are one-time use and are safely discarded.**
- **According to data, the COVID-19 vaccine has approximately a 94% success rate in completely protecting those who receive it. The remainder have partial protection and will have greatly lessened symptoms if they do contract COVID-19.**
- **The vaccine will begin to provide protection about one to two weeks after the second shot of the series is given.**
- **At this time, we do not know how long the COVID-19 vaccine is effective for, so you may need future vaccines to remain protected.**
- **While the COVID-19 vaccination does provide protection against infection or greatly lessened symptoms if you contract COVID-19, you should continue to practice hand hygiene and use appropriate personal protective equipment (PPE).**
- **We encourage you to register for the CDC's "V-safe" after vaccination health checker program by registering at https://vsafe.cdc.gov/**

WHAT TO DO IF YOU HAVE A REACTION TO THE COVID-19 VACCINATION

- Most people have side effects from the vaccination, but these usually only last 24 – 48 hours after receipt of the vaccination. A few people may have no side effects at all. Most people will experience pain, redness and/or soreness at the injection site. Many people will have a headache, fever, chills, muscle pain and/or fatigue from the vaccine, particularly after the second dose. A few people will have nausea or swollen lymph nodes (lymphadenopathy).
- In rare circumstances, the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness).

What should you do if you have a reaction?

If you experience any of the following:

- Red, sore arm at and around the injection site:
  - Apply an ice pack to the affected area for comfort.
  - If condition does not improve or worsens in 24 to 48 hours, call your physician.
- Fever, achiness, fatigue and/or headache:
  - Take the non-prescription product that you would usually use for discomfort or fever relief as needed.
  - If condition does not improve or worsens in 24 – 48 hours, call your physician.
- Unusual or severe reaction (for example, hives, difficulty breathing, wheezing, allergic reaction):
  - Immediately call 911
- If you have seen your physician or visited the emergency room or an urgent care in relation to any of the reactions listed above, please notify our staff by calling 912-355-2462 during business hours.
- In addition, you may report vaccine side effects to the FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html Please include "Pfizer-BioNTech COVID-19 Vaccine EUA" in the first line of box #18 of the report form