ID Verified ________ **Patient may leave at: __________________**

LOVELACE FAMILY MEDICINE COVID-19 VACCINE CONSENT FORM FOR DATE OF VACCINATION

LAST NAME	FIRST NAME (LEGAL)	DATE OF BIRTH	AGE
SOCIAL SECURITY #	ADDRESS		
CITY	COUNTY	STATE	ZIPCODE
PHONE	EMAIL		
GENDER	RACE/ETHNICITY:	TYPE OF WORK	
INSURANCE COMPANY	POLICY/MEMBER ID	NO INSURANCE	

Question		
HAVE YOU EVER HAD A COVID-19 VACCINE? YES NO	BRAND	DATE RECEIVED
ARE YOU FEELING SICK TODAY? YES NO		
HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR THAT CAUSED YOU TO GO TO THE HOSPITAL?	YES	NO
HAVE YOU RECEIVED ANY VACCINES IN THE PAST 14 DAYS?	YES	NO
HAVE YOU EVER TESTED POSITIVE FOR COVID-19? YES NO	IF YES, WHEN?	
HAVE YOU RECEIVED MONOCLONAL ANTIBODIES OR CONVALESCENT PLASMA FOR TREATMENT OF COVID-19?	YES	NO
DO YOU HAVE A WEAKENED IMMUNE SYSTEM CAUSED BY SOMETHING SUCH AS HIV, CANCER, OR USE OF IMMUNOSUPPRESSIVE THERAPIES?	YES	NO
ARE YOU PREGNANT OR BREASTFEEDING?	YES	NO
ARE THERE ANY REASONS WHY YOU CANNOT RECEIVE YOUR INJECTION IN YOUR LEFT ARM?	YES	NO

By signing below, you acknowledge the following:
The Food and Drug Administration has approved the vaccine being administered to you on an emergency use basis as a vaccination for SARS-CoV-2 (Coronavirus or COVID-19), after having found it to be safe and effective in accordance with Emergency Use Authorization requirements. Information about the vaccine has been made available to you in the form of the Emergency Use Authorization (EUA) Fact Sheet/VIS form. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. The vaccine is administered over 2 doses, and in order to be effective, you will need to receive both doses. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.

I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheets/VIS relating to the vaccine I will be receiving and I accept all risks associated with such. I authorize Lovelace Family Medicine to release all information necessary to process my claims and provide the services above.

RECIPIENT/PATIENT SIGNATURE:	DATE:

FOR STAFF USE ONLY

Pfizer BioNTech Covid-19 Vaccine Lot # ______________________________ Exp. ______________________________

Dose #: (circle) 1st dose / 2nd dose	Date of Service:
Site: (circle) Left Deltoid / Right Deltoid	Administered by:
Monitor for 15 min / 30 min	Scanned by: ____________ Documented by: ____________
Chart # ______________________________	Next Vaccination: ______________________________