Pfizer or Moderna Bivalent COVID-19 Vaccine Boost Dose Consent

Developed 9.6.22

Public Health

Section 1: Vaccine Recipient Information

Recipient Name: _____
Last First M.I.

Address: _____ _____
Street City State Zip Code Phone Number

Date of Birth: _____ Age: _____ (12 or older) Gender: ☐ Male ☐ Female

Primary Healthcare Provider: _____ Personal Email Address: _____

Section 2: Screening for Vaccine Eligibility: Circle---Prime or Boost

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

If yes circle the previous vaccine received: Pfizer, Moderna, or Johnson and Johnson

Date 1st dose administered: _____ Date of 2nd dose_____ Date of 3rd dose: _____ 4th Dose: _____

Vaccine requested today? Moderna or Pfizer (Pfizer is the only bivalent mRNA boost dose vaccine approved for 12-17 year-olds)

Section 3: Health status review:

Are you feeling sick today?	☐ Yes	☐ No
Do you have a health condition or are you undergoing treatment that makes you moderately to severely immunocompromised?	☐ Yes	☐ No
Have you had a previous severe allergic reaction to any vaccine or injectable therapy?	☐ Yes	☐ No
If yes, have you consulted with an allergist or immunologist?	☐ Yes	☐ No
Do you have a history of pericarditis or myocarditis?	☐ Yes	☐ No
If yes, have you consulted with your health care provider?	☐ Yes	☐ No
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No
Do you have a history of multisystem inflammatory syndrome related to COVID infection?	☐ Yes	☐ No
If yes, have you consulted with your health care provider?	☐ Yes	☐ No
Are you currently experiencing symptoms of COVID or tested positive for COVID?	☐ Yes	☐ No
Have you had a severe allergic reaction to any component to the Moderna or Pfizer vaccine?	☐ Yes	☐ No
Have you received hematopoietic cell transplant or CAR-T cell therapy since receiving COVID vaccine?	☐ Yes	☐ No
Have you had a severe allergic reaction requiring treatment with an EpiPen or an allergic reaction that caused hives, swelling or caused hives, swelling, or respiratory distress? (includes food, pet, meds)	☐ Yes	☐ No
Have you had a reaction, including fainting, to a previous dose of COVID-19 vaccine?	☐ Yes	☐ No
Do you have dermal fillers?	☐ Yes	☐ No
Do you have a contraindication to a different type of COVID-19 vaccine?	☐ Yes	☐ No

Section 4: Insurance: Please provide medical insurance information for the vaccine recipient.

Insurance Name: _____ Member ID: _____ Group ID#_____

Cardholder Name: _____Relationship to Vaccine Recipient: _____

Cardholder's Date of Birth_____

Section 5: Consent

I have read or had explained to me information provided in the Emergency Use Authorization (EUA) or EUI Factsheet 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.

Signature: _____ Date: _____

Healthcare Provider Use Only

Immunization Date	Brand & Lot #	Dosage, Route & Site *(circle)*	Vaccinator Signature	Entered in IRIS Date and Initials
		0.25 ml or 0.3 ml or 0.5 ml IM L deltoid or R deltoid		

☐ Moderna or Pfizer COVID-19 Bivalent Vaccine EUA/EUI FACT SHEET for Recipients and Adult Vaccination Card provided.

☐ Consent reviewed with patient. Patient initials and date _____