Pfizer-BioNTech COVID-19 Vaccine Consent Form for Individuals Under 18 Years of Age

Section 1: Patient Information

Child's Name (Last, First, MI): _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Section 2: Information on the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine

The Pfizer-BioNTech COVID-19 Vaccine may prevent the person vaccinated from getting COVID-19. There is no U.S. Food and Drug Administration (FDA)-approved vaccine to prevent COVID-19. However, the FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 12 years of age and older under an Emergency Use Authorization (EUA). The PfizerBioNTech COVID-19 Vaccine is administered as a 2-dose series, 3 weeks apart, into the muscle.

The Pfizer-BioNTech COVID-19 Vaccine may not protect everyone. Side effects that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the Pfizer-BioNTech COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Pfizer-BioNTech COVID-19 Vaccine. For this reason, a vaccination provider may ask the person receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body. The Pfizer-BioNTech COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" is available at https://www.fda.gov/media/144414/download.

Section 3: Consent

CONSENT FOR MINOR'S VACCINATION: I have reviewed the information on risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine in Section 2 above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

3. I understand I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child will receive the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.
4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the PfizerBioNTech COVID-19 Vaccine. The government is paying for the Pfizer-BioNTech COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
5. **I GIVE CONSENT** for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in Section 3 of this form. (If this consent is not signed, dated and returned, the child will not be vaccinated.)

Signature of Legally Authorized Representative:	
Printed Name of Legally Authorized Representative:	
Date:	

COVID-19 Encounter Form

Date of Service: ___6/23/2021_____

Address: Charles Towne Pediatrics, 3800 Faber Place Dr, North Charleston, SC 29405 Provider_____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Sex: _____Race: _____Ethnicity: _____

Product Name: COVID 19 Vaccine **Mcf:** Pfizer-BioNTech **Lot#: _____**
NDC#: 59267100002 **Exp Date: _____**

Time Vaccine Administered: _____ Vaccine Administered by (Print Name): _____

CPT Codes

Covid-19 Vaccination (Pfizer)	91300____
Administration FIRST Dose	0001A____
Administration SECOND Dose	0002A____

Diagnosis Code

Encounter for Immunization	Z23____

NOTES:

Patient here today for Covid-19 Vaccine. Patient given vaccine IM in _____arm. Patient tolerated procedure well after waiting 15 minutes.

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____