Pfizer COVID-19 BOOSTER Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: ___/___/___	Age:
EMAIL:			GTID#
DAYTIME PHONE NUMBER		GENDER: Male ☐ Female ☐ Other ☐	
EMERGENCY CONTACT: Name:	Relation:	Phone Number:	

Please answer the questions below:	Yes	No
1. Are you feeling sick today?	☐	☐
2. Did you have a **severe** reaction to any COVID-19 vaccination received?	☐	☐
3. List the dates of your Pfizer COVID-19 vaccine. **Pfizer Only** 1st dose _____ 2nd dose _____		
4. Has it been at least **six** months since your second COVID-19 vaccination?	☐	☐
5. Please select the appropriate response below.		
A. Are you 65 years and older?	☐	☐
B. Are you 50–64 years of age with underlying medical conditions? *(Medical conditions criteria per CDC. Cancer, Kidney Disease, Chronic lung diseases, Dementia or other neurological conditions, Diabetes, Down Syndrome, Heart conditions, HIV, Immunocompromised, Liver disease, Obesity, Pregnancy, Sickle cell, Smoking, Solid organ or blood stem cell transplant, Stroke or cerebrovascular disease, Substance use disorders)*	☐	☐
C. Are you 18–49 years of age with underlying medical conditions?	☐	☐
D. Are you 18-64 years of age who are at increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?	☐	☐

I, the undersigned, wish to receive the **Pfizer COVID 19 BOOSTER vaccine.** I understand that the Food and Drug Administration amended the emergency use authorization (EUA) for the Pfizer-BioNTech COVID-19 Vaccine to allow for use of a single booster dose, to be administered at least six months after completion of the primary series. I hereby certify that the foregoing answers to the health questions are true and complete to the best of my knowledge. I understand that a "YES" response to any of the health questions above may require that a Stamps Health Services provider talk with me prior to getting the Pfizer COVID 19 BOOSTER vaccine at a GT vaccination clinic. I understand the benefits and risks of the **Pfizer COVID 19 BOOSTER vaccine** and had the chance to ask questions. I have been advised to remain on site for 15 minutes after receiving the vaccine. For any reaction to a previous COVID-19 vaccination, I have been advised to stay for 30 minutes.

_____ _____ X_____

Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	____ml 3rd	☐ IM - L Arm ☐ IM - R Arm		Pfizer			

☐ **Guest Account**
☐ **MyTest Data Inaccuracy**
☐ **MyTest ID Number** _____