DKH DAY KIMBALL HEALTHCARE

Day Kimball Hospital
320 Pomfret St. Putnam, CT 06260

NAME: _____ DATE OF BIRTH: _____ SCHOOL: _____

PFIZER COVID-19 VACCINE CONSENT FORM

	Yes	No
Are you 12 years of age or older?	☐	☐
Are you currently sick with a fever or infection?	☐	☐
Do you have a bleeding disorder or are you on a blood thinner?	☐	☐
Do you have any allergies or have you had a severe allergic reaction after a previous dose of this vaccine?	☐	☐
Are you immunocompromised or are you on a medicine that affects your immune system?	☐	☐
Are you pregnant or plan to become pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Have you received another COVID-19 vaccine?	☐	☐
Have you ever had a reaction to any of the ingredients in the Pfizer COVID-19 vaccine which include: messenger ribonucleic acid (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 have read or have had explained to me the current Fact Sheet for Recipients and Caregivers, Emergency Use Authorization of the Pfizer-BioNTech COVID-19 Vaccine dated 4/6/21. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to me.

_____ _____ _____

Signature Date Time

PLEASE COMPLETE DEMOGRAPHICS ON BACK

For Vaccinator to complete:

Vaccine: Pfizer-BioNTech COVID-19 Vaccine ☐ #1 ☐ #2

Lot#: EW0173 Exp. 08/2021 **Site**: _____ deltoid

Administered by:_____Date:_____ Time:_____

Patient Information

PLEASE PRINT:

NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

GENDER: _____

ETHNICITY/RACE: _____

SCHOOL: _____

Insurance Policy Holder's Information

PLEASE PRINT:

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH_____

INSURANCE COMPANY (i.e., Anthem, Blue Cross, ConnectiCare)**:** _____

ID#:_____ **POLICY #:** _____ **GROUP#:**_____

EMPLOYER: _____

If different from above:

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____