LEGACY MEDICAL CARE
Pfizer SARS-CoV-2 Vaccine (COVID-19)
5-11 CONSENT FORM AND ADMINISTRATION RECORD

CLEARLY PRINT information below about the person receiving the vaccine.

Last Name: ________________________ **First Name:** ____________________ **Middle Name:** ______________
Date of Birth: ________________ **Sex:** ☐ Male ☐ Female ☐ Other
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Choose not to disclose
Race: ☐ American Indian/ Alaskan Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic/Latino
☐ Native Hawaiian/ Other Pacific Islander ☐ Other Race/Multiracial ☐ Prefer not to disclose.
Home Address: __________________________________ **City:** ______________ **State:** ____ **Zip:** __________
County: _________________ **Phone Number** _______________________

Please answer all the questions below.

1. Are you under 5 years or over 11 years of age? .... ☐ YES ☐NO
2. Are you currently in quarantine or isolation? .... ☐ YES ☐NO
3. Have you been treated for Covid with monoclonal antibodies or convalescent plasma in the last 90 days? ☐ YES ☐NO
4. Are you experiencing moderate or severe acute illness with or without fever including any COVID symptoms?.. ☐ YES ☐NO

If you answered YES to any of the questions above this clinic is not able to provide the vaccine at this time.

5. Have you received MMR/Varicella/Proquad vaccines in the past 30 days? .... ☐ YES ☐NO
6. Have you received a vaccine in the last 14 days? .... ☐ YES ☐NO
7. Have you tested positive for COVID? .... ☐ YES ☐NO
   If yes, when? ____
8. Do you have a bleeding disorder or are you taking anticoagulants (Aspirin/Warfarin/Coumadin)? .... ☐ YES ☐NO
9. Have you ever had a serious reaction to a vaccine/injectable medication (e.g., anaphylaxis)?................ ☐ YES ☐NO
10. Are you allergic to any of the ingredients in the COVID vaccine?.. ☐ YES ☐NO

NOTE: Please continue to protect yourself and others from COVID-19 with good hand washing, wearing a mask, maintaining social distance of at least 6 feet from others, and staying home when you are ill.

CONSENT: I have been given and read the Emergency Use Authorization (EUA) for the Pfizer/Comirnaty Vaccine and have had my questions answered about COVID-19 vaccine. I understand the benefits and the risks of the COVID-19 vaccine and ask that the vaccine be given to me. Pfizer/Comirnaty primary series requires 2 doses, 21 days or more apart, to be fully effective. I agree to obtain the second dose.
I consent to the administration of the vaccine by representatives of Legacy Medical Care (LMC). I fully release and discharge Legacy Medical Care, its affiliates and their officers, directors, employees, and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or my receipt of, the vaccine.
If you are under 18 years old, your custodial parent or a legal guardian may consent on your behalf and sign this form; minors may not consent for vaccination unless they are emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the IL Consent by Minors Act. If I am signing this document on behalf of a minor, I affirm that I have legal authority to consent to the minor's medical care.
I attest I am eligible for the vaccine I am requesting per IDPH guidelines.

SIGNATURE: ____________________________________ *Relationship to minor:* ____________________________ *Date:* ___________
(If a minor a parent or legal guardian must sign)

First and Last name of an additional individual who is authorized to bring the minor to receive the COVID-19 vaccine:
First Name: ______________________ Last Name: ______________________ Relationship to minor: __________________

FOR ADMINISTRATIVE USE ONLY

Administration Date	**Vaccine Manufacturer Pfizer COVID-19 Lot #**	***Vaccine Administrator Signature Title***	**Route I M** *(Circle)*	**Dose Administered**
			R deltoid L deltoid	0.2 mL

☐ New Patient ☐ Established Patient Insured: ☐ YES ☐ NO

Information entered in I-CARE: Initials: ______ Date_____/_____/______

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