Virginia Garcia Memorial
HEALTH CENTER

COVID-19 Vaccine Acknowledgment (Patient)

VIRGINIA GARCIA MEMORIAL HEALTH CENTER
PO BOX 6149
ALOHA, OREGON 97006

This information is for the person getting the vaccine:

Last Name: _____ First Name: _____ DOB: _____

Previous last name, if any: _____ Cell Phone: _____ Other Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____

	Yes	No	Don't Know
1. **Have you ever had a dose of COVID-19 vaccine?**			
• If yes, which vaccine product did you receive? ☐Pfizer ☐Moderna ☐Another product			
2. **Have you received any vaccine in the last 14 days?** (Stop- do not vaccinate)			
3. **Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?**			
• If yes, were you given antibody therapy in the last 90 days? (Stop- do not vaccinate)			
• If yes, was your positive test in the last 10 days? (Stop- do not vaccinate)			
4. **Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?**			
• If yes, was the severe allergic reaction after receiving a COVID-19 vaccine? (Stop- do not vaccinate)			
• If yes, was the severe allergic reaction after receiving another vaccine or another injectable medication?			
5. Have you ever fainted after injections?			
6. Do you have any of the following conditions? ☐ Feeling sick, fever, chills, cough **today** ☐ Weakened immune system or taking medicine that affects your immune system ☐ Bleeding disorders or taking blood thinners ☐ Pregnant or breastfeeding			

01/05/2021 CS321629-E Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklist

CONSENT: I have received the Emergency Use Authorization (EUA) form. I have reviewed the information provided and have had my questions answered. I am voluntarily receiving the vaccine and know what to do if I have side effects. I understand that Virginia Garcia is required to share information about the vaccine I receive with the state vaccine registry.

For official use only: Vaccine Administration Documentation

Person administering vaccine (name & credential): _____ Vaccine given: ☐Pfizer ☐Moderna ☐Another product

_____ Dose & unit: _____ Lot number: _____

Administration time: _____ Administration date: _____ Route: _____ Vaccine expiration date: _____

Site: ☐ Left deltoid ☐ Right deltoid Other (indicate location) _____ EUA version date: _____

Parent or Guardian Consent Form
Pfizer Covid-19 Vaccination for individuals 12-14 Years Old

This information is for the person receiving the vaccine:

Last Name: First Name: DOB:

Emergency Use Authorization
The FDA has made the Pfizer COVID-19 Vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Information on the Risks and Benefits of the Pfizer COVID-19 Vaccine
The Pfizer-BioNTech (Pfizer) COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" is available at https://www.fda.gov/media/144414/download.

Parent or Guardian
I have reviewed the information on risks and benefits of the Pfizer COVID-19 Vaccine 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 COVID-19 Vaccine.
2. I have the legal authority to consent on behalf of the child/minor named above to receive the Pfizer COVID-19 Vaccine.
3. I understand I am not required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent below, the child/minor will receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment.
4. I understand that a second dose of Pfizer vaccine is required to complete the series.
5. I have completed the Virginia Garcia Vaccine Administration Acknowledgement Form for the child/minor named above, and understand that these forms must be completed for both vaccine doses.

I GIVE CONSENT for the child/minor named at the top of this form to get vaccinated with the two-dose Pfizer COVID-19 Vaccine and have reviewed and agree to the information included in this form. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed (if this consent is not signed, dated and returned, the child/minor will not be vaccinated).

_____ _____
Printed Name Relationship to Minor

_____ _____
Signed Name Date

***Note**: Under Oregon law, minors 15 years of age and older may consent to medical treatment, including vaccinations, when provided by a physician, physician assistant, naturopath, nurse practitioner, dentist.*