Pfizer-BioNTech COVID-19 Vaccine Consent Form for Individuals 12-17 Years of Age

Section 1: Information about the child to receive Pfizer-BioNTech COVID-19 Vaccine *(please print)*:

Child's Name (Last, First, MI) | *Date of Birth (mm/dd/yyyy)* | *Age*

Street Address

City | *State* | *Zip*

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 Pfizer-BioNTech 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 am not accompanying the child named above to their vaccination appointment, I will provide a completed pre vaccination screening form, available at: www.mass.gov/CDCScreeningForm
5. 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 Pfizer- BioNTech 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.
6. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

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 *Date*

MASCON MEDICAL

LAST MILE VACCINE DELIVERY

BREWSTER AMBULANCE SERVICE

COVID-19 VACCINE SCREENING and CONSENT FORM

FIRST NAME : _____

LAST NAME : _____

MIDDLE NAME : _____

DOB : _____

ADDRESS : _____

APT# : _____

EMAIL : _____

City : _____ ZIP : _____

INSURANCE : _____

PHONE : _____

DOSE# :

- ☐ 1st DOSE
- ☐ 2nd DOSE

MEMBER# : _____

GROUP# : _____

RACE :

- ☐ White
- ☐ Black-African American
- ☐ Asian
- ☐ Pacific Island
- ☐ Hawaiian
- ☐ American Indian
- ☐ Alaska Native

GENDER :

- ☐ Male
- ☐ Female
- ☐ Not reporting / Other

ETHNICITY :

- ☐ Non - Hispanic
- ☐ Hispanic
- ☐ Unknown

SCREENING for COVID-19 VACCINE ELIGIBILITY

Please circle **YES** or **NO** for each question

Is the recipient feeling sick today?	**YES**	**NO**
Is the recipient under 18 years of age?	**YES**	**NO**
Has the recipient received any vaccinations within the last 14 days?	**YES**	**NO**
Has the recipient ever received a dose of COVID-19 vaccine?	**YES**	**NO**
If yes, which vaccine product did recipient receive? ☐ Pfizer ☐ Moderna ☐ Another product		
Has the recipient ever had a severe allergic reaction following a previous dose of COVID-19 vaccine?	**YES**	**NO**
Does the recipient currently have any symptoms of COVID-19?	**YES**	**NO**
Is the recipient currently pregnant, breastfeeding or plans to become pregnant and has not discussed receiving the vaccine with their OB/GYN Provider?	**YES**	**NO**

Has recipient 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.)	**YES**	**NO**

- A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.
- Polysorbate
- A previous dose of COVID-19 vaccine

Did the recipient have a confirmed case of COVID-19 ≤ 90 days ago?	**YES**	**NO**
Has the recipient received monoclonal antibody treatment for COVID-19 ≤ 90 days ago?	**YES**	**NO**
Does the recipient have a history of anaphylactic allergic reactions to a vaccine or injectable medication?	**YES**	**NO**
Has the recipient recieved passive antibody therapy (monoclonal antibodies vs convalescent serum) as treatment for COVID-19?	**YES**	**NO**
Does the recipient have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	**YES**	**NO**
Does the recipient have a bleeding disorder or are you taking a blood thinner?	**YES**	**NO**

IF ANY QUESTIONS LISTED ABOVE ARE ANSWERED YES, PLEASE REFER TO THE ONSITE STAFF FOR CLARIFICATION

CONSENT for VACCINE ADMINISTRATION and BILLING:

I have been provided with the Emergency Use Authorization (EUA) for COVID-19 Vaccine Information Sheet. I have read or have had explained to me the information provided about the COVID-19 Vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination. I voluntarily consent to administration of the COVID-19 vaccine and assume the risk for any reactions that may result. **I agree to stay in the building for 15 minutes (30 minutes if I have a history of an anaphylactic allergic reaction to any vaccine or injectable medication**. I understand I may experience soreness or swelling at the injection site, fever or generally not feel well for 24-48 hours. If symptoms become severe, I will contact my primary care provider or seek emergency care.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Brewster Ambulance Service now, in the past, or in the future, until such time as I revoke this authorization in writing. I agree to immediately remit to the ambulance service any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to the ambulance service. I authorize the ambulance service to appeal payment denials or other adverse decisions on my behalf.

I authorize and direct any holder of medical, insurance, billing ot other relevant information about me to release such information to the aforementioned ambulance service and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by the ambulance service, now in the past, or in the future. I also authorize the aforementioned to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

☐ By checking this box and signing below, I attest that I am uninsured

DATE : _____ SIGNATURE : _____ PRINT NAME : _____

AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section only if the patient is physically or mentally incapable of signing.

Describe the circumstances that make it impractical for the patient to sign:_____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Brewster Ambulance Service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

☐ Patient's legal guardian

☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient

☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs

☐ Representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the patient

DATE : _____ SIGNATURE : _____ PRINT NAME : _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Site	Date Dose Administered
COVID-19 ☐ 0.5 mL ☐ 0.3 mL	1M	☐ R-Deltoid ☐ L-Deltoid	
Vaccine trade name/Manufacturer	**Lot Number**	**Expiration Date**	**Name & Title of Vaccine Administrator**