Islands Community Medical Services, Inc.

Pfizer-BioNTech COVID-19 Vaccine Consent Form for Minors

1. PATIENT INFORMATION

Patient's Last Name				Patient's First Name	
Date of Birth Year	Month	Day	Age	☐ Male ☐ Female ☐ Self-identify: _____	
Insurance ID #				Email	
Address				Race: _____ Ethnicity:_____	Cell / Home Phone

2. HEALTH ASSESSMENT (Please answer questions for your child named above)

a) Have you been sick recently? Do you have COVID-19 symptoms or a fever?	◯ YES ◯ NO
b) Do you have any severe allergies? Have you ever had an anaphylactic reaction?	◯ YES ◯ NO
c) Have you ever had a serious reaction to a vaccine before? To polyethylene glycol?	◯ YES ◯ NO
d) Are you pregnant, breastfeeding or planning a pregnancy?	◯ YES ◯ NO
e) Do you have an autoimmune disorder, or weakened immunity due to illness/treatment?	◯ YES ◯ NO
f) Do you have any neurological disorder, bleeding disorder or taking a blood thinner?	◯ YES ◯ NO
g) Do you have a history of fainting?	◯ YES ◯ NO
h) Have you received a flu vaccine or any vaccine in the past 14 days?	◯ YES ◯ NO

Pfizer-BioNTEch mRNA Ingredients

Active Ingredients:

- Nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2

Inactive Ingredients:

- 2[(polyethylene glycol {PEG})- 2000]-N, N-ditetradecylacetamide
- Cholesterol
- (4-hydroxybutyl)azanediyl)bis(hexane6,1-diyl)bis(2-hexyldecanoate)
- Sodium chloride
- Monobasic potassium phosphate
- Potassium chloride
- Dibasic sodium phosphate dehydrate
- Sucrose

3. CONSENT FOR VACCINATION

I have read the attached Pfizer vaccine fact sheet. I understand the expected benefits and possibler risks and side effects of the vaccines. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine. I have had the opportunity to have my questions answered by ICMS.

I authorize Islands Community Medical Services, Inc. to administer the Pfizer vaccine to my child.

X _____ _____

Signature of Patient **Date**

4. SCREENING FOR PATIENTS WITH HEALTH CONDITIONS: ☐ N/A

☐ **YES, Patient is Eligible for Vaccination**

- If it has been 3 months post-chemotherapy and the cancer is in remission
- If immunosuppression therapy has been discontinued for at least 3 months
- If immunosuppression therapy has been discontinued for at least 6 months for anti-B cell antibodies
- With stable hepatitis B or C, or living with HIV
- Using blood thinner medication

☐ **Patients on anticoagulant therapy** (blood thinner medication)
Use a small gauge needle and apply pressure to injection site for 3 to 5 minutes after vaccination to reduce bruising. There is no need to measure the blood thinning level (INR test) prior to vaccination. Continue INR testing according to the schedule recommended by the attending physician.

5. VACCINE ADMINISTRATION: Nurse to Complete

Pfizer COVID-19 Vaccine: Two Dose Series-3 weeks apart-Intramuscular

Dose 1: **0.3mL** ☐	**Dose 2:** **0.3mL** ☐
IM Injection to deltoid left ☐ right ☐	IM Injection to deltoid left ☐ right ☐
Lot # expiry date:	Lot # expiry date:
loading nurse:	loading nurse:
dosing nurse signature:	dosing nurse:
dosing date & time:	dosing date & time:

Notes:

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act. Information may be shared with the Maine CDC and Maine State Immunization Program.