COVID-19 VACCINE CONSENT FORM

NAME: _____ **DATE OF BIRTH:** _____ **AGE:**_____

ADDRESS: _____, **NJ ZIP CODE:** _____

PHONE NUMBER: _____ **HOME OR CELL**

RACE: _____ **ETHNICITY:** _____

PLACE OF BIRTH: _____ **SINGLE OR MULTIPLE BIRTH**

1. Have you completed your Pre-Vaccination Checklist? **YES NO**

Reviewed by Nurse: _____

Comments:

I have read, or have had explained to me, the CDC Emergency Use Authorization Form about the Pfizer Vaccine. I acknowledge that I have been given the opportunity to review the PHCTR Notice of Privacy Practices on this date. I understand that this vaccine may cause symptoms in some people but will not actually cause the Covid Virus. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Covid vaccine and request that the vaccine be given to me or for whom I am authorized to make this request. I have answered all questions truthfully and accurately.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Name of Vaccine :_____ Dose number : _____

Manufacturer:_____

Lot number :_____ Expiration date: _____ LEFT RIGHT DELTOID

_____ _____

Administered by Date