Maricopa County Department of Public Health Consent for Immunization
PLEASE PRINT

Office Only
ASIIS #: _________________

First Name: ______________________________________ Last Name: ____

Street Address: ____________________ City: ___________ Zip Code: _____________ Phone Number: ___________

Race: □White □Asian □Black or African American □Hispanic □American Indian or Alaska Native □Native Hawaiian or Other Pacific Islander □Other

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino

Male □ Female □ Date of Birth: Month ____________ Day __________ Year __________ Age: _____________

Insured for vaccines? No □ Yes □ Name of Insurance:____________________________ ID/SS#____________________

For patients to be vaccinated

The following questions will help us determine if there is any reason, we should not give you Pfizer/BioNTech COVID-19 Vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Do you have a history of severe allergic reaction to any component of the vaccine, specifically Polyethylene glycol or PEG?
   Yes □ No □
   If yes divert or alternately route to a physician consult.

2. Do you have a history of severe allergic reaction to another vaccine or injectable medication?
   Yes □ No □
   If yes recommended to observe for 30 minutes

3. If you have an immunocompromised condition, are pregnant or breastfeeding have you had the opportunity to discuss the decision to vaccinate with your healthcare provider and/or are you ready to proceed with vaccination? Yes □ No □
   If Yes, proceed with vaccination.
   If no, provide immunosuppression, pregnancy, lactation fact sheet and pull out of the line to determine whether they would like to be vaccinated at this visit.

☐ **I have been given a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE Pfizer/BioNTech COVID 19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 12 YEARS OF AGE AND OLDER.**

Patient signature:________________________ Printed signature________________________ Date___________

Staff Only:

Vaccine Administration: Pfizer/BioNTech Covid-19 vaccine □ Site:_____________________________________

Signature_______________________________ Date___________________

Vaccine label or lot number________________ Expiration Date__________ NDC number_________________