Full Name: _____

Telephone: _____ Date of Birth: _____ Gender: _____

In which arm do you want your shot? ▢ L ▢ R

I have been given a copy and have read, or have explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and the risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I consent to receive the vaccine in a public location. I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. I understand the risks of the vaccine requested and ask that the vaccine be given to me, or in the case that I am a guardian, my child.

I certify that I am 16 years old and eligible to receive Pfizer vaccine. ▢ **YES** ▢ **NO**

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Fill out on 05/05/21 - Screening Questionnaire for Immunization	YES	NO	UNSURE
1. Are you sick today? (Fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)			
2. Are you currently in your isolation or quarantine period due to COVID-19?			
3. Have you ever had an observed anaphylactic reaction? If so, was it to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy? List:			
4. Have you received antibody therapy or convalescent plasma for COVID treatment in the past 90 days?			
5. Have you received another vaccine in the past 14 days? List:			
6. Have you received a dose of the COVID vaccine? If yes, which product? _____ Date of First Dose: _____			

Deerfield First Doses May 5, 2021