COVID-19 (PFIZER) VACCINE SCREENING AND CONSENT FORM

I hereby certify that I do not have any Covid-19 symptoms (Respiratory and other) and have not been a close or casual Covid-19 contact in the last 2 weeks.

Name Signature .... Date

FIRST NAME
LAST NAME
DATE OF BIRTH
ADDRESS

PLEASE ANSWER ALL QUESTIONS BELOW	YES	NO
Do you have respiratory symptoms or feel ill today?		
Have you previously had an allergic reaction to any vaccine?		
Do you have any serious allergies, particularly anaphylaxis, to anything?		
Do you have cardiac illness or congenital heart disease?		
Do you have a mast cell disorder?		
Have you received another vaccine in the past 7 days?		
Are you pregnant?		
Have you had COVID 19 before?		
Do you have any problems with your immune system or are you taking any medications that can affect your immune system?		
Do you have an autoimmune disease?		
Do you have a bleeding disorder or are taking medication that could affect blood clotting?		
Have you ever felt faint after a past vaccination or medical procedures?		
Have you had COVID vaccine before?		

P.S A rare side effect of myocarditis (heart inflammation) and pericarditis (inflammation of the lining of the heart) following vaccination with the Pfizer vaccine has been detected.

I have read and understand COVID 19 vaccination screening and give consent to receive the vaccine. I agree to wait the required 15-30mins post vaccination for monitoring an adverse reaction.

Name:

Signature Date:

If signing on behalf of the Patient, circle your authority - Legal Guardian / Authorised Carer