AUTHORIZATION FOR CORONAVIRUS DISEASE 2019 (COVID-19) VACCINATION

Vaccine: Administration of Pfizer SARS-COV-2 (COVID-19) mRNA Vaccine

Risks to the Patient: Outlined on 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 5-11 YEARS OF REVIEWED WITH AND RECEIVED BY PATIENT AND GUARDIAN.

By signing below, I am consenting to receive the COVID-19 Vaccine and represent that:

- A practitioner has talked with me about the vaccine and explained the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization of the COVID-19 Vaccine, including common risks with any vaccine and any risks that may apply to me. There may be unknown complications that have not been identified to date.
- I understand that in addition to the Responsible Practitioner, other individuals, including Nursing and non-physician staff, may perform important tasks related to my vaccination, in accordance with their scope(s) of practice and SSMH policies.
- My questions about the vaccine have been answered to my satisfaction.
- I have voluntarily chosen to receive the vaccine and consent to the administration.
- I am of legal age and authorized to execute this authorization form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the patient.
- I am aware the COVID-19 vaccine does not provide 100% protection against getting COVID-19.
- I will immediately alert the Provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
- I understand I should remain in the monitoring area until I am released by Samuel Simmonds Memorial Hospital staff.

Patient Name _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Phone Number:_____ Address:_____

Date _____ Time _____

main 907 852 4611 | 1 800 525 7764 | PO Box 29 Utqiaġvik, Alaska 99723 | samuelsimmonds.org