



RSK-4513-FRM  
REV 0 05.13.2021

## Pfizer Vaccination Consent Form

NAME: _____	DATE OF BIRTH: _____
Print First and Last Name	MM/DD/YYYY
STREET ADDRESS: _____	
CITY: _____	STATE: _____ ZIP: _____
EMAIL ADDRESS: _____	
PHONE NUMBER: _____	

**The Pfizer-BioNTech COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19 in individuals 12 years of age and older under Emergency Use Authorization (EUA).**

- I hereby acknowledge that I have read, or been informed of the nature and advisability of the risks and complications inherent in, and the expected benefits of, the alternative to and their risks and benefits, and the probable consequences of receiving The Pfizer-BioNTech COVID-19 Vaccine. I have had the opportunity to ask my physician or his/her designee any and all questions that I may have and I have NO additional questions. However, as with all medical treatment, I recognize there is no guarantee that I will become immune or that I will not experience any adverse side effects from the vaccine.
- I understand the benefits and risks associated with The Pfizer-BioNTech COVID-19 Vaccine and I consent (or the person named above for whom I am authorized to make this request) to the administration of The Pfizer-BioNTech COVID-19 Vaccine.
- Note: In South Carolina, individuals 16 and older are able to consent to vaccination without parental permission. They do not need to be accompanied to a vaccine appointment by a parent or guardian.
- Note: South Carolina's Department of Health and Environmental Control has determined that although parental consent is required for administration of The Pfizer BioNTech COVID-19 Vaccine to persons 12 to 15 years of age, a parent or guardian is not required to be present at administration.

Signature of Person Receiving Vaccination:

\_\_\_\_\_ Date/Time: \_\_\_\_\_

Signature of Patient's Personal Representative/Parent or Guardian (if applicable):

\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_