THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

PATIENT:
MDA MRN: CSN:
ACCT#: DOB:
ADM DATE: LOCATION:
DISCHARGE DATE: SEX: FC:
PRINT DATE: 5/27/2021;

Pfizer BioNTech COVID-19 Vaccine Dose 1 and 2 Attestation

Please read completely and sign below to attest to your understanding and agreement of the following for yourself or your child/minor. I declare that I (and/or my child/minor):

- Is 12 years of age or older;
- Have received information about the possible side effects of the Pfizer COVID-19 vaccine, as presented in the Emergency Use Authorization fact sheet;
- Voluntarily agree to receiving Dose 1 and 2 of the COVID-19 vaccine at MD Anderson, after carefully considering the risks and benefits;
- Have not received treatment for symptomatic COVID-19 with monoclonal antibody therapy (i.e. bamlanivimab, casirivimab, or imdevimab), or convalescent plasma in the last 3 months;
- Have not recently tested positive for COVID-19, and if so, have completed the 10-day quarantine before the vaccine appointment;
- Am aware that there may be unknown side effects of the COVID-19 vaccine;
- Should consult with a medical provider to discuss personal risks and benefits of receiving the COVID-19 vaccine;
- Understand that if I (or my child/minor) have ever experienced a severe allergic reaction, I (or my child/minor) may have a greater risk of experiencing a severe allergic reaction to the Pfizer COVID-19 vaccine (including problems breathing, swelling of the face and throat, a fast heartbeat, a bad rash all over the body, dizziness, and weakness);
- Understand to proceed with caution if I (or my child/minor) have ever experienced a severe allergic reaction to a vaccine or medicine injected in the skin, muscle, or veins, and that I (or my child/minor) should discuss with a personal medical provider whether or not to receive the Pfizer COVID-19 vaccine at this time;
- Understand that I (or my child/minor) should not receive the Pfizer COVID-19 vaccine if I (or my child/minor) have ever experienced a severe allergic reaction to a component of this vaccine, which includes polyethylene glycol (used in many injectable medications), potassium chloride, sodium chloride, sucrose, and cholesterol;

- Understand that I (and my child/minor) must remain in a designated observation area for 15-30 minutes after the vaccination so that on-site medical staff can assist in case of a severe allergic reaction to the COVID-19 vaccine;

- Understand that if I (or my child/minor) experience a severe adverse reaction after leaving the designated observation area, I should call 9-1-1 or immediately go the nearest hospital emergency room (ER);

- Understand that I (or my child/minor) must complete the 2-dose series of the Pfizer COVID-19 vaccine, unless instructed otherwise by a medical provider;

- Understand that I will receive a COVID-19 vaccination card today showing that I (or my child/minor) have received the first dose of the Pfizer COVID-19 vaccine, and that I should bring this vaccination card with me for the second dose of the Pfizer COVID-19 vaccine;

- Understand that the COVID-19 vaccines given at MD Anderson will be tracked and reported, as required by the state and federal government, and that information shared about me (or my child/minor), as part of this process, will be limited to my (or my child/minor's) full name, date of birth, gender, race, ethnicity, address, and whether I am school or childcare personnel;

- Acknowledge receipt of the UT MD Anderson Notice of Privacy Practices (NPP). I understand that a copy of the NPP is available to me at the time of vaccination, upon my request, or by reviewing on the website;

- Understand the importance of continuing to wear a mask, washing hands, and keeping social distance even after receiving the COVID-19 vaccine; and

- Understand that my insurance may be billed for the COVID-19 vaccine administration fee, and that my insurance carrier should process the vaccine administration charge without applying any out-of-pocket costs to me.

_____ _____

Printed Name of Patient or Child's Parent/Legal Next of Kin Date

_____

Relationship to Child/Minor (if applicable)

_____

Signature of Patient or Child's Parent/Legal Next of Kin

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