WHAT ARE THE RISKS OF THE COVID-19 VACCINE? 2024-2025

As with any medicine, there are risks that may cause serious problems. The risk of a vaccine causing serious harm or death is extremely small. Serious problems from the COVID vaccine are very rare. *As with any vaccine, Pfizer Comirnaty may not be 100% effective for all individuals.*

If the following mild or moderate problems occur, they usually start soon after the vaccination and usually last up to 1-2 days.

- Soreness, redness, or swelling at the injection site.
- Fever or body aches.

DO NOT TAKE THIS VACCINE IF YOU HAVE:

- had a severe allergic reaction to a previous dose of Comirnaty or any Pfizer-BioNTech COVID-19 vaccine or to any ingredient in these vaccines.

BEFORE GETTING COMIRNATY, TALK TO YOUR HEALTH CARE PROVIDER IF YOU:

- have a fever
- are pregnant, plan to become pregnant, or are breastfeeding
- have a bleeding disorder or are on blood thinner
- A moderate or severe illness now
- A serious allergy to latex rubber

WHAT TO DO IF THERE IS A SERIOUS REACTION:

- Call your doctor or go to an emergency room right away
- Write down what happened and the date and time it happened

DATE VACCINATED:_____

MFG:Pfizer Comirnaty**: COVID:** _____ _____

If you want to learn more, ask your doctor or nurse. She/He can give you the vaccine package insert or suggest other sources of information.

I have read or have had explained to me the information on this form about COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine, and I request that it be given to me or to the person named below for whom I am authorized to make the request**.**

INFORMATION ON THE PATIENT TO RECEIVE THE COVID-19 VACCINATION: 2024-2025

NAME_____ BIRTHDATE_____
Last First Initial (mm/dd/yy)

PHONE #_____

SIGNATURE: _____
Person to receive the vaccine or (authorized person)

MEDICARE PATIENTS MUST SIGN PAYMENT AUTHORIZATION:

"I request that payment under the Medical Insurance Program be made to the provider named on any bills for the services furnished me during the effective period of the authorization and I authorize the above-named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original."

SIGNATURE: _____ DATE: _____
Patient or Authorized person

For office use only

Rogue Valley Physicians, PC

CLINIC LOCATION: **SOIM** INJECTION SITE: **RD** **LD**

MFG: Lot #: _____ _____ **INITIAL:** _____