Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

Viraj V. Tirmal, MD LLC

Dear Patient,

The COVID-19 vaccination is recommended for all patients for the prevention of COVID-19. We currently offer the Pfizer COMIRNATY® (COVID-19 Vaccine, mRNA) vaccine in our office. Vaccination is especially important for people at highest risk of severe COVID-19, including people ages 65 years and older; people with underlying medical conditions, including immune compromise; people living in long-term care facilities; and pregnant people to protect themselves and their infants. The CDC recommends that patients receive all recommended COVID-19 vaccine doses.

Please answer the following questions to help determine your eligibility for the vaccine today:

	Yes	No
Do you feel sick today (For example: a cold, fever, or acute illness)?	☐	☐
Have you received a COVID-19 vaccine? If so, when was your last dose?	☐	☐
Did you bring your vaccination record card or other documentation?	☐	☐
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐
Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications (including injectable therapies), latex, or foods? *Examples: COVID-19 vaccine, polyethylene glycol (PEG), polysorbate, eggs, yeast, preservatives, phenol, thimerosal, streptomycin, neomycin, gelatin, latex, bovine protein. *This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.*	☐	☐
Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?	☐	☐
Have you received a vaccine in the past 4 weeks?	☐	☐
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?	☐	☐
Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?	☐	☐
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?	☐	☐
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome, a condition which causes paralysis?	☐	☐
Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, organ transplant, cancer, or take immunosuppressive drugs or therapies? *This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.*	☐	☐
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 48 hours?	☐	☐

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	Yes	No
Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?	☐	☐
Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐

Consent

I certify that I am: (i) the Patient; or (ii) the patient's personal representative. I consent to, or give consent for, the administration of the COVID-19 vaccine. I have been provided the patient fact sheet corresponding to the COVID-19 vaccination given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered. I have been given the opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I have been given the opportunity to ask questions and understand the benefits of vaccination as provided in this document.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccine administration.

I understand if I experience side effects that I should contact the office and/or call 911.

I hereby release Viraj V. Tirmal, MD, LLC and its officers, employees, and agents, respectively, from any and all liability that might arise from this vaccination.

Patient Name (printed): _____

Date of Birth: _____

Patient or Patient's Personal Representative Signature*: _____
**A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*

Date: _____

Patient Personal Representative Name (printed):

_____

Personal Representative Type: _____

Submit

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