WILTON
MEDICAL CENTRE
WILTON | CORK

CONSENT FOR PFIZER VACCINE

Complete if requesting vaccination.

I verify that I have been provided with and have read (or had read to me) (1) the Fact Sheet for the COVID-19 Pfizer Vaccine; (2) this COVID-19 Vaccine Consent Form for the Pfizer Vaccine; and (3) any additional information provided to me concerning COVID-19 vaccination. I acknowledge that I have had a chance to ask questions of a medical professional about the Pfizer Vaccine. I understand that the Pfizer Vaccine will be given in two separate doses, three/four weeks apart. I understand the known risks and the potential benefits of receiving the Pfizer Vaccine, and I understand there may be risks to the Pfizer Vaccine that are not known at this time. I understand that the HSE and EU has authorized use of the Pfizer Vaccine. I request and consent to the Pfizer Vaccine being given to me.

I understand it is recommended that I remain on site for at least 15 minutes after receiving the Pfizer Vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.

Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

Email Address (***Please put an email address below which is mandatory for appointment confirmation) if you or a family member don't have one, please speak to reception.***

(**BLOCK LETTERS**) ______________________________

Mobile Number (***for appointment confirmation)*** ______________________________