COVID-19 Pfizer Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER M / F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
STUDENT'S DOCTOR'S NAME (Last, First)	**Address**	**City**	**Zip**	
SCHOOL NAME	**HOMEROOM TEACHER'S NAME**		**GRADE**	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if your child can get the COVID-19 vaccine. If you answer "NO" to all of the following questions, your child can probably get the COVID-19 vaccine. If you answer "YES" or DON'T KNOW to one or more of the following questions, your child may be able to get the COVID-19 vaccine, but we will contact you to discuss your options. Please mark YES, NO, or DON'T KNOW for each question.

	YES	NO	DON'T KNOW
1. Has your child ever had an allergic reaction to: (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. Itwould also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
●Polyethylene glycol (PEG), which is found in some medications, such as laxatives andpreparations for colonoscopy procedures			
●Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
●A previous dose of COVID-19 vaccine.			
●A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19vaccine component, but it is not known which component elicited the immediate reaction.			
2. Has your child ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or thatcaused 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.)			
3. Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? (This would include food, pet, venom, environmental, or oral medication allergies.)			
4. Has your child received any vaccine in the last 14 days?			
5. Has your child ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? If yes, what is the date of the positive test? _____			
6. Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			

7. Does your child have a weakened immune system caused by something such as HIV infection or cancer or doyou take immunosuppressive drugs or therapies?			
8. Does your child have a bleeding disorder or are you taking a blood thinner?			
9. Is your child pregnant or breastfeeding?			
10. Does your child receive frequent lip or face dermal fillers?			

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the COVID-19 Pre-vaccination Checklist and understand the risks and benefits. Please check one of the boxes below, then sign and date.

☐ **I GIVE CONSENT** to the Coplin Health Systems and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

☐ **I GIVE CONSENT** to the Coplin Health Systems and its staff for my child named at the top of this form to be vaccinated with this vaccine without parent/guardian being present.

Signature of Parent/Legal Guardian _____

Date: month_____day_____year_____

OFFICE USE ONLY

Vaccine	1st/2nd dose	VFC/AVAP	Admin Site	Lot #	Manufacturer	EUA Fact Sheet Date
☐						
☐						

Provider name (print) _____

Provider name (signature) _____

☐ Refer to _____ for _____

☐ Adverse Event _____ ☐ VAERS Report completed_____

***Adverse Event Type ☐ Local ☐ Syncope ☐Anaphylaxis**

***(If there was an adverse event, an event type must be selected.)**

Arrival Time _____

Exit Time _____

Administration Sites	
Left Deltoid IM	LDI
Right Deltoid IM	RDI

Name_____

Birth Date_____

Date_____