

VaccinatorSignature_

COVID-19 Immunization Screening and Consent Form*: Children and Adolescents Ages 5-11 years old

Rec	ipient Name (please	print)			Preferred Name									
DOB		Indicate II	Gender ID D Below:	TM- Transgen Q- Not sure/C	W- Woman/Girl TM- Transgender Man/Boy Q- Not sure/Questioning			GNL- Gender not Listed (write-in) TW- Transgender Woman/Girl NB- Non-Binary Person *Gender Pronouns: write-in by client's name				NR- Chose not to Respond M- Man/Boy GNC- Gender Non-Conforming		
Sex Assigned at Birth Key: Indicate Sex Below: M- Male F- Female I- Intersex NR- Chose not to respond				Indicate Status Below: S-			V- Widowed			M- Married U-Unknown ner				
Add	dress				City State Zip Ema					Email /	il Address			
Par	ent/Guardian/Surrog		Phone				Preferred Language							
	nicity cate Ethnicity Below:	NHL- Non-Hispanic (UNK- Unknown	- Unknown			Key: AlA- Native American or Alaskan BAA- African American or Black NHP- Native Hawaiian or Pacific			WHT- White ASN- Asian DECL- Decline OTH- Other or Multiracial					
Clinic/Office Site Where Vaccine is Administered Primary Care Physician Address/Phone Number														
		Screening Questionnaire											•	
1. 2.		re you between the ages of 5 and 11 years old?									□ Yes	□ No		
3.	Are you 12 years old or older? Are you feeling sick today?										□ Yes	□ No		
4.	In the last 10 days have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider										□ Yes	□ No	□ Unknown	
5.	health department to isolate or quarantine at home due to COVID-19 infection or exposure? Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive that last dose? Date:										□ Yes	□ No	□ Unknown	
6.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?										□ Yes	□ No	□ Unknown	
7.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?										□ Yes	□ No	□ Unknown	
8.	Do take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?										□ Yes	□ No	□ Unknown	
9.	Do you have a bleeding disorder, a history of blood clots or are you taking blood thinner?										□ Yes	□ No	□ Unknown	
10.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart?										□ Yes	□ No	□ Unknown	
11.		Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine?									□ Yes	□ No		
12. Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, sinopharm/BIBP)?											□ Yes	□ No	□ Unknown	
Emergency Use Authorization The FDA has made the COVID-19 vaccines available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below. Consent The vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, understand that a booster dose of COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if a may member of a certain population (e.g., 65 years or older, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition, 18-49 years old with an underlying medical condition, 18-49 years old and a manufaction of the propose and transmission because of working or living in a high-risk setting and based on individual benefits and risks, 18-64 years old and a rain increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and based on individual benefits of the vaccination were always as described. I have had a chance to ask questions which were answered to my satisfaction (and ensu														
Telephonic Interpreter's ID # Date/Time OR														
Signature: Interpreter Date/Time Print: Interpreter's Name and Relationship to Patient Area Below to be Completed by Vaccinator														
Area Below to be Completed by Vaccinator Which vaccine is the patient receiving today?														
	Vaccine Name	Ĭ		Administration	Administration			EUA Fact Sheet Date			Manufacturer & Lot Number			
Pfiz	D5:/D:-NTI-			□ Second Dose										
Moderna N/A N/A			N/A											
Jan	ssen		N/A											
Administration Site			□ Right Deltoid	□ Left 1	Thigh	□ Right Th	nigh							
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□ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.