COVID-19 Vaccine Consent Form

Pediatrics, P.C.
Infancy through Adolescence

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

Name: Date of Birth: Age: Sex (circle): M F

Address:

City/State/Zip: Phone:

Section 2: Screening for Vaccine Eligibility

Has this person been vaccinated with the COVID-19 vaccine? (circle) Yes No

Section 3: Consent

I understand I either have or will receive the Emergency Use Authorization (EUA) fact sheet prior to the administration of the vaccine and have the ability to revoke consent at any time.

Your signature indicates that you give consent to Pediatrics, PC and its staff for the person named at the top of this form to be vaccinated with this vaccine.

Patient signature OR Signature of Parent/Legal Guardian

X _____ **Relationship** _____

Date: _____ /_____ /_____

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Section 4: Vaccine Administration Record

Injection Site (Deltoid) please circle:
Left Right

Manufacturer:
Pfizer Moderna AstraZeneca Johnson & Johnson

Lot #: _____ Exp: _____

The vaccine administrator's signature below attests that the vaccine recipient's identity has been confirmed and that the vaccine recipient has been properly screened according to the CDC guidelines and recommendations.

Vaccine Administrator (signature):

X _____ Date: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
3. Have you 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. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists