COVID-19 VACCINE SCREENING AND MINOR CONSENT FORM

Pfizer-BioNTech tŜŘĭl-ứǌλŎ óрèπммềύ COVID-19 Vaccine

SECTION 1: PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle Initial

Date of Birth			Age in Years	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race			Ethnicity
☐American Indian or Alaska Native	☐Native Hawaiian or Other	☐Other	☐Hispanic or Latino
☐Asian	☐Pacific Islander		☐Not Hispanic or Latino
☐Black or African American	☐White		☐Unknown

Address		
City	State	Zip Code
Cell Phone Number	Mother's Maiden Name	

Is this the patient’s first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	YES	NO
1. Are you sick today?	☐	☐
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?	☐	☐
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?	☐	☐
4. Have you had any other vaccinations in the previous 14 days?	☐	☐
5. In the past 90 days, have your received monoclonal antibodies or been diagnosed with COVID-19?	☐	☐
6. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	☐	☐

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	YES	NO
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:	☐	☐
10. Are you immunocompromised or on a medicine that affects your immune system?	☐	☐
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	☐	☐
12. Have you received a previous dose of any COVID-19 vaccine? If yes, please indicate which manufacturer's vaccine you received and date the dose was administered: ☐ Pfizer-BioNTech COVID-19 vaccine ☐ Date administered: ____________________	☐	☐
13. Did you experience a non-severe allergic reaction within 4 hours of a previous dose of COVID-19 vaccine? Non-severe allergic reactions can include: hives, swelling, redness, wheezing, GI symptoms, etc)? If yes, please explain:	☐	☐

- I certify that I am: (a) the parent or legal guardian of the patient and confirm that the patient is between the ages of 5 years old and 11 year old; or (b) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Howard County Health Department (HCHD) to administer the COVID-19 vaccine.
- I understand that the patient is receiving a product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 5 year of age to 11 years of age; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with the patient receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected for the patient to receive the vaccine. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination.
- I acknowledge that the patient will be advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary. If the patient experiences a severe reaction, 9-1-1 will be contacted.
- I voluntarily elect to for the patient to receive the COVID-19 vaccination at HCHD after carefully considering the risks and benefits.
- I understand that the COVID-19 vaccinations given at HCHD will be tracked and reported to ImmuNet and as otherwise required by the local, state and federal government.

Signature of Parent/Guardian or Authorized Representative: _____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____