



COVID-19 Vaccine Screening and **Parent/Legal Guardian/Legal Custodian** Consent for Covid-19 Vaccine

**Section 1A: Information about the minor/ (please print)**

Last:	First:	MI:
DOB:	Phone Number:	S.S. #:
Address:		Apt/Room #:
City:	State:	Zip:
Email:		
<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Race:</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
Primary Insurance Carrier ID #: _____		
Insurance Company: _____		
Secondary Insurance Carrier ID #: _____		
Insurance Company: _____		
<b>Dose to be received today::</b> <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input checked="" type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> Monovalent Booster (Pfizer age 5-11) <input type="checkbox"/> Bivalent Booster (Pfizer age 12-17) <small>(4<sup>th</sup> dose for immunocompromised)</small>		

**Section 1B: Information about the parent/guardian/custodian (please print)**

Last:	First:	MI:
Address: <small>(If different from above)</small>		
City:	State:	Zip:
<b>Responsible Party's Relationship to Patient:</b>		

**FOR ADMINISTRATION USE:**

Site (LD/RD)	Route	Manufacturer (MVX)	Lot #	Expiration Date	EUA
	IM				
Administered at location: Facility Name/ID					
Administered at location: Type					
Administration Address:					

**Registration**  
Apply Sticker in this Field

Vaccinator Print Name: \_\_\_\_\_

Vaccinator Signature: \_\_\_\_\_

Immunization Date: \_\_\_\_\_

Circle Site (LD/RD) <input type="checkbox"/> LD <input type="checkbox"/> RD
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**Immunizer**  
Confirm and Apply Sticker in this Field

**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 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?		
3. In the past two weeks, have you tested positive for COVID-19?		
4. Do you have allergies or reactions to any medications, foods, vaccines, or latex?		
5. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
6. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
7. Have you had any other vaccinations in the last 14 days?		
8. Have you ever had an allergic reaction to another vaccine or an injectable medication?		
9. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine? (including Polyethylene Glycol found in some medications or Polysorbate)		
10. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive. <u>Manufacturer:</u> <u>Date:1</u> <u>Date:2</u> <u>Date:3</u>		
11. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
12. For <b>women</b> , are you pregnant or is there a chance you could become pregnant or breastfeeding?		

- I certify that: (a) the patient is at least 6 months of age; (b) I am the legal guardian of the patient; (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Pennsylvania Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- I understand that this 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 6 months of age and older; 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 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 to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless the State of Pennsylvania, the Pennsylvania Department of Health (DOH), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Pennsylvania SIRS, Pennsylvania's immunization registry and (b) DOH will include my personal immunization information in Pennsylvania SIRS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

**Print Name of Responsible Party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Responsible Party:** \_\_\_\_\_

**Witness #1 Signature:** \_\_\_\_\_

**Witness #2 Signature:** \_\_\_\_\_