

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. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> ● 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. ● A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine 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 that caused 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?			
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 do you 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 Cabell-Huntington Health Department (CHHD) and Valley Health (VH) and its staff for my child named at the top of this form to be vaccinated with this vaccine. I understand that this is a two dose series and CHHD and VH will return to the school in 3 weeks to provide the second dose of vaccine. (By signing this consent you agree for your child to receive both doses of the vaccine).

I DO NOT GIVE CONSENT to the Cabell-Huntington Health Department and Valley Health and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: month_____day_____year_____

Vaccine Information:

Type Viral Vector Product COVID 19 Manufacturer Pfizer Lot Number _____ Exp. Date _____

Date Administered _____ Administration Site: Left Arm / Right Arm Administration Route _____

Contraindications Identified No _____ Yes _____

Dose Number 1 Signature _____

Vaccine Information:

Type Viral Vector Product COVID 19 Manufacturer Pfizer Lot Number _____ Exp. Date _____

Date Administered _____ Administration Site: Left Arm / Right Arm Administration Route _____

Contraindications Identified No _____ Yes _____

Dose Number 2 Signature _____