Spencer Hospital
Clay County Public Health
Healthier Together.

Pfizer COVID-19 Vaccine Screening & Consent

5-11 year olds

☐ 1st Dose ☐ 2nd Dose

Name: ______________________________ Date of Birth: ______________ Gender: ☐Female ☐ Male

Address: ____________________________City: ______________________State: ______ Zip: _________

Phone Number: ___________________________ Medical Provider: ________________________________

Parent/Legal Guardian authorized to consent for vaccine: ____

Phone Number (if different than above): __________________________

Please answer the questions below for the child. If you answer 'yes' to any questions, it does not necessarily mean the vaccine won't be given. It just means additional questions must be asked.

1. Is the child feeling sick today? ☐ Yes ☐ No ☐ Don't Know

2. Has your child ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving another vaccine or injectable medication? ☐ Yes ☐ No ☐ Don't Know

3. Check all that apply to the child:

   ☐ Had a severe allergic reaction to something other than a vaccine such as food, pet, venom, environmental or oral medication allergies
   ☐ Has a weakened immune system or on a medicine that affects the immune system
   ☐ Has a bleeding disorder
   ☐ Takes a blood thinner
   ☐ Has fainted with an injection in the past
   ☐ Has been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   ☐ Has a history of myocarditis or pericarditis

Vaccination Release

This Pfizer-BioNTech COVID-19 Vaccine is FDA-authorized under Emergency Use Authorization (EUA) for those 5-11 years of age. I have read or have had explained to me the information in the **VACCINE INFORMATION FACT SHEET FOR RECEIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 5 THROUGH 11 YEARS OF AGE (10-29-21).** I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine. I have the legal authority to consent to the administration of this vaccine to the person named on this form.

Parent/Guardian Name: ________________________ Signature: ______________________ Date: _______

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Office Use Only

Date:	Manufacturer	Lot #	Exp Date	EUA Fact Sheet	Dose	Site	Adm By	IRIS date/initial
	Pfizer			10/29/2021	0.2ml	R Deltoid L Deltoid		