



COVID-19 Immunization Screening and Consent Form: *Children and Adolescents Ages 6 Months–11 Years Old

Recipient Name (please print) Preferred Name
Address City State Zip Email Address
Parent/Guardian/ Surrogate (if applicable, please print) Phone Preferred Language
DOB Current Gender ID Key: W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy
Indicate ID Below: TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming
Q – Not Sure/Questioning NR – Chose not to Respond
GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name
Sex Assigned at Birth Key: M – Male F – Female Marital Status Key: S – Single D – Divorced M – Married
Indicate Sex Below: I – Intersex Indicate Status Below: W – Widowed V – Civil Union
NR – Chose not to Respond U – Unknown SEPARATED – Legally Separated
PARTNER – Life Partner
Ethnicity Key: DECL – Declined Race Key: AIA – Native American or Alaskan ASN – Asian
Indicate Ethnicity Below: HIS – Hispanic Origin Indicate Race Below: BAA – African American or Black DECL – Declined
NHL – Non-Hispanic Origin NHP – Native Hawaiian or Pacific Islander
UNK – Unknown WHT – White OTH – Other or Multiracial
Primary Insurance Name Primary Insurance ID# Subscriber Name/DOB Subscriber Relation to Patient
Primary Insurance Address Primary Insurance Group # Primary Insurance Phone #
Secondary Insurance Name Secondary Insurance ID# Subscriber Name/DOB Subscriber Relation to Patient
Secondary Insurance Address Secondary Insurance Group # Secondary Insurance Phone #
Clinic/Office Site Where Vaccine is Administered Primary Care Physician Address/Phone Number

Screening Questionnaire

1. Are you between the ages of 6 months and 11 years old? [] Yes [] No
2. Are you feeling sick today? [] Yes [] No
3. In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure? [] Yes [] No [] Unknown
4. Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose? Date: _____ [] Yes [] No [] Unknown
5. Have you ever had an immediate allergic reaction (e.g., hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything? [] Yes [] No [] Unknown
6. Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system? [] Yes [] No [] Unknown
7. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments? [] Yes [] No [] Unknown
8. Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner? [] Yes [] No [] Unknown
9. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)? [] Yes [] No [] Unknown
10. Do you have a history of MIS-C (Multisystem Inflammatory Syndrome in Children)? [] Yes [] No [] Unknown
11.* Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine? [] Yes [] No Date: (if applicable) _____
12.** Are you between the ages of 5–11 and received 2 doses of Pfizer or Moderna vaccine with the second dose being at least 2 months ago, OR are you between the ages of 6 months–4 years old and received 2 doses of the Moderna vaccine with the second dose being at least 2 months ago? [] Yes [] No Date: (if applicable) _____

13.	Have you received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by the FDA (AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm / BIBP, Covaxin, Serum Institute of India – NUVAXOVID, or CanSino Biologics - Convidecia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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*Question 11 pertains to primary series only. Note: children receiving Pfizer ages 6 months–4 years of age require a 3-dose primary series, 2 doses of monovalent, and 1 dose of bivalent

**Question 12 pertains to booster dose eligibility. Note: children ages 6 months–4 years of age who received Pfizer for a primary series are not eligible for a booster of any type at this time. Children ages 6 months–4 years of age who received Moderna for a primary series are eligible for a Moderna bivalent booster only.

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA’s decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 12 years of age and older; and approved the Moderna COVID-19 vaccine as a two-dose series in individuals 18 years of age and older. These vaccines continue to be available under an EUA for certain populations, including Pfizer-BioNTech COVID-19 vaccine for those individuals 6 months to 11 years old, and Moderna COVID-19 vaccine for individuals 6 months to 17 years old and for the administration of a third dose in the populations set forth in the consent section below.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose of COVID-19 vaccine is recommended for those 6 months–4 years of age who received Moderna as a primary series and those 5 years of age and older at least 2 months following the completion of a COVID-19 vaccine primary series or a monovalent booster dose to increase my protection. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian Signature Date / Time Print Name Relationship to Patient (if other than recipient)

Telephonic Interpreter’s ID # Date / Time

OR

Signature: Interpreter Date/ Time Print Interpreter’s Name and Relationship to Patient

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	Administration				Manufacturer & Lot #	EUA Fact Sheet Date
Pfizer/BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Bivalent Third Dose (6 months–4 years)	<input type="checkbox"/> Bivalent Booster (5 years–11 years)		
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	<input type="checkbox"/> Bivalent Booster (6 months–11 years)			
Administration Site	<input type="checkbox"/> Left Deltoid	<input type="checkbox"/> Right Deltoid	<input type="checkbox"/> Left Thigh	<input type="checkbox"/> Right Thigh		
Dosage	<input type="checkbox"/> 0.2 ml	<input type="checkbox"/> 0.25 ml	<input type="checkbox"/> 0.3 ml	<input type="checkbox"/> 0.5 ml		

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____