Coffey Health System

COVID-19 VACCINATION SCREENING AND CONSENT FORM

Pediatric (Age 5-11)

Patient Label

Patient First and Last Name *(please print)*	MI	Date of Birth

Address	City	State	Zip

Phone Number	Email	Name of Primary Care Provider

SCREENING FOR VACCINATION ELIGIBILITY

1. Has the child to be vaccinated ever had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Has the child to be vaccinated ever had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nano particles or polyethylene glycol (PEG)?	Yes	No
3. Has the child to be vaccinated received convalescent plasma or monoclonal/polyclonal antibody infusion for COVID-19 with the past 90 days?	Yes	No
4. How old is the child?		
5. Is the child currently sick? For example, currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Does the child have a bleeding disorder or are they taking a blood thinner?	Yes	No
7. Has the child tested positive for COVID-19 in the last 10 days?	Yes	No
8. Is the child currently in quarantine for COVID-19 exposure?	Yes	No
9. Has the child ever been diagnosed with Multisystem Inflammatory Syndrome in the last 90 days? If you answer yes to this question, it is recommended you consult with your child's physician prior to receiving the COVID-19 vaccine.	Yes	No
10. Has the child ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. Has the child ever received a dose of the COVID-19 Pfizer BioNTech vaccine?	Yes	No
12. If this is the child's second dose, what was the date of their first vaccination?	/ /	

CONSENT FOR DEPENDENT'S VACCINATION & RELEASE OF VACCINATION INFORMATION

I have read the information contained in the Emergency Use Authorization Fact Sheet for Recipients and Caregivers presented to me for the Pfizer BioNTech COVID-19 vaccine for ages 5-11, and understand the risks and benefits of the vaccine. I have had a chance to ask questions which have been answered to my satisfaction I understand the benefits and risks of the vaccine. I understand that if my dependent exhibits disruptive behavior while staff is trying to administer the vaccine, they will not receive the vaccine at this clinic and will have to be taken to their provider for this vaccine.

I understand following my dependent's vaccination, I will be required to remain with my dependent at the vaccination clinic site for a 15- to 30-minute monitoring period.

By signing this form, I give permission for a vaccine to be administered to the person above for whom I am authorized to make this request, and I consent to inclusion of this immunization data to in the Kansas Immunization Registry.

Patient or Authorized Representative Signature **Date**

Relationship to Patient *(If applicable)*