VACCINATE LOMPOC COVID-19 SHOT CLINIC

Ages 12+ Pfizer (no cost for vaccine)

FILLED BACKPACK GIVEAWAYS

Backpacks for children K-12th Grade*

(While supplies last, supplies may vary)

*Vaccination not necessary to receive backpack

FRIDAY AUGUST 6 2-6 PM

Lompoc Valley Medical Center
1515 E Ocean Ave
Lompoc, CA 93436

Pediatrician on-site for questions!
Spanish interpretation on site!

LompocVMC.com/Backpack

LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

SANTA BARBARA COUNTY PROMOTORES NETWORK
TRANSFORMANDO COMUNIDADES • TRANSFORMING COMMUNITIES

LVCHO
Lompoc Valley Community Healthcare Organization, Inc.
HEALTHY LOMPOC

NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF COLORED PEOPLE
NAACP
FOUNDED 1909

Santa Barbara County PUBLIC Health DEPARTMENT

TOGETHER TOWARD HEALTH

Funding is provided by Together Toward Health, a program of the Public Health Institute, through funding from a group of philanthropic organizations.

Pfizer-BioNTech COVID-19 Vaccine Consent
For Individuals Under 18 Years of Age

I have been given a copy of and have read, or have had explained to me, the information contained in the FDA Emergency Use Authorization (EUA) Recipient Fact Sheet for the Pfizer COVID-19 vaccine for persons 12 years and older:
https://www.fda.gov/media/144414/download

1. I reviewed this consent form and understand the risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named below vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named below to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. By signing below, I acknowledge I have been made aware of the Notice of Privacy Practices of Santa Barbara County Public Health Department. It is available at https://countyofsb.org/ceo/hipaanoticesofprivacy.sbc. It provides information about how Santa Barbara County Public Health Department uses and discloses protected health information.
5. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record web form.
6. By providing my cell phone number and/or email address below, I give the Santa Barbara County Public Health Department and participating vaccination partners permission to contact me regarding important vaccine reminders.

Please complete both pages, sign, and date.

Child's First Name: _____ **Child's Last Name**: _____

Birthdate: mm/dd/yyyy _____ **Gender**: ☐ Male ☐ Female ☐ Other

Parent/Guardian First Name: _____ **Parent/Guardian Last Name:** _____

Email: _____ **Contact Phone:** _____

Address: _____ **City**: _____

Zip code: _____

Screening Questions **Please Answer the Following Questions (check one)**		
1	Have you ever received a dose of COVID-19 Vaccine? If Yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson&Johnson)	☐ Yes ☐ No
2	Are you feeling sick?	☐ Yes ☐ No
3	Have you ever had an allergic reaction to: 1. Component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, 2. Polysorbate, 3. A previous dose of COVID-19 vaccine (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.)	☐ Yes ☐ No
4	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) 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.)	☐ Yes ☐ No
5	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐ Yes ☐ No
6	Have you received any vaccine in the last 14 days?	☐ Yes ☐ No
7	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ Yes ☐ No
8	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No
9	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No
10	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No
11	Are you pregnant or breastfeeding?	☐ Yes ☐ No

I GIVE CONSENT for the child named above to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

_____ _____

Signature of Parent/Guardian or Caregiver Date