COVID-19 Vaccine
Pediatric Consent Form

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Parent/Guardian: Answer the following questions to help us safely give your child COVID-19 vaccine. Vaccine is free. No ID or insurance required.

Child Information			
Last name	First name	Middle initial	Phone number
Mailing address	City	State	Zip code
Email address	Birthdate / Age		Do you have health insurance? ☐ Yes ☐ No
Race (check all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____ ☐ Decline to answer	Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Decline to answer	Sex assigned at birth ☐ Female ☐ Male	Gender identity ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Genderqueer/non-binary ☐ Other_____

Parent/Guardian Signature

I have received, read/had explained to me, and understand the COVID-19 vaccine emergency use authorization (EUA) information sheet. I am the parent or legal guardian of the above child and I give my permission for my child to receive COVID-19 vaccine. I understand the benefits and risks of COVID-19 vaccine. I understand my child's immunization information will go into a database other medical providers and school staff use.

Parent/Guardian name (printed) _____ Parent/Guardian signature _____ Date _____

Phone number _____ Email address _____

For office use only				
Dose ☐ 0.3 ml IM ☐ _____	Site ☐ RA ☐ LA	Manufacturer	Lot #	Exp
Date EUA info sheet given	Date EUA published	Appointment? ☐ Yes ☐ No	Appointment date	
Vaccinator name (printed)	Vaccinator signature	Date		

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name

Age

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
◦ If yes, which vaccine product did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
◦ Have you received a complete COVID-19 vaccine series *(i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])*?	☐	☐	
◦ Did you bring your vaccination record card or other documentation?	☐	☐	
3. Have you 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
◦ A component of a COVID-19 vaccine, including either of the following: o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
◦ A previous dose of COVID-19 vaccine	☐	☐	☐
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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by

Date

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists