SSMHealth

5-11 years PATIENT PFIZER-BioNTech COVID-19 VACCINE CONSENT FORM

Patient Name: _____

Date of Birth: _____ Home Address: _____ City: _____

State:_____ County:_____ Zip Code: _____Email: _____

Screening Questions - Do not administer if the answer is NO

1. Is your child between 5-11 years of age?	Yes	No	
2. If receiving second dose, was first dose at least21 days ago?	Yes	No	N/A
3. For ***immunocompromised patients*** receiving the completion dose, was the second COVID vaccine dose at least 28 days ago?	Yes	No	N/A

Bivalent Booster Screening - Do not administer if the answer is NO

4. Is your child between 5-11 years of age?	Yes	No
5. Has it been at least two months since completing the primary series (Pfizer, Moderna) or receiving a monovalent booster dose (Pfizer, Moderna)?	Yes	No

Do not administer vaccine if the answer is YES

6. Does your child feel ill today, or do you have a fever? COVID-19 Symptoms: T >/=100.0 F, respiratory symptoms (cough, shortness of breath), new loss of smell and/or taste, headache, sore throat or muscle pain.	Yes	No
7. Has your child been diagnosed with Multisystem Inflammatory Syndrome (MIS) with symptoms starting in the last 90 days?	Yes	No
8. Has your child tested positive for COVID-19 in the past 10 days?	Yes	No
9. *History of severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or any of its components?	Yes	No
10. *History of an immediate allergic reaction of any severity to a previous dose of a COVID-19 vaccine or any of its components? (include polyethylene glycol (PEG))	Yes	No
11. *History of immediate allergic reaction of any severity to polysorbate?	Yes	No

*Should not receive the COVID-19 vaccination at this time unless they have been evaluated by an allergist-immunologist and it is determined whether the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available).

Monitor if YES

12. Does your child have a condition that makes them bruise or bleed easily? (if yes, monitor for bleeding post vaccination)	Yes	No
13. History of an immediate allergic reaction of any severity to a vaccine or injectable therapy (intramuscular, intravenous, or subcutaneous or therapies not related to components of the COVID-19 vaccine or polysorbate) or a history of anaphylaxis due to any cause? (if yes, should be observed for 30 minutes)	Yes	No

I hereby certify that the foregoing history is true and complete to the best of my knowledge. I understand that this COVID-19 vaccine is authorized for emergency use and not approved by the FDA for ages 5-11. I have received and read the "Vaccine Information Fact Sheet for Recipients and Caregivers" and have had an opportunity to ask questions. The known and potential risks and benefits of the vaccine, as well as available alternatives, have been explained to me. I understand that I can accept or refuse the vaccine. If I am an employee or otherwise affiliated with SSM. I give permission to share information concerning my receipt of the vaccine with SSM Health's Employee Health Department if needed. I hereby consent to the administration of the COVID-19 vaccine for myself or to the above named minor or incapacitated person:

Date:_____ **Relationship (Circle one): Self Parent Legal Guardian *Responsible Person**

Signature:_____ **Print Name:**_____

Type of Vaccine	Dosage	Lot#	Expiration Date	Dose Number
Primary Monovalent Series: Pediatric Pfizer-BioNTech COVID-19 Vaccine	**0.2 mL**			
Bivalent Booster: Pediatric Pfizer-BioNTech COVID-19 Vaccine	**0.2mL**			

Site: Left Deltoid _____ Right Deltoid _____

Vaccine Administrator Signature: _____ Date given: _____

Print Name: _____Vaccine information provided: ☐ Yes ☐ No

*The term "responsible person" means the parent, legal guardian or responsible adult if the patient is a minor or an incapacitated person.