School:_____

HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

COVID-19 Pfizer Vaccination Consent Form

*If child is already a South Royalton Health Center patient, **only** complete Sections 1 & 3*

SECTION 1

Student's / Participant's Information:

Name _____

Address _____

Student's Date of Birth _____

Student's Social Security # _____

Regular Primary Care Provider _____

Gender: ☐ Male ☐ Female ☐ Other

SECTION 2

Parent's Address and Phone:

Name _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

MEDICAL INSURANCE INFORMATION

Policy Guarantor/ Holder/subscriber:

Name: _____

Date of birth _____

Relationship to student: _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Primary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

SECTION 3

COVID-19 VACCINE CONSENT:

I certify that I am the patient and at least 18 years of age, or the parent or legal guardian of the patient.

- I have been given a copy of the Emergency Use Authorization (EUA) for Vaccine Recipients or the Vaccine Information Statement for the COVID-19 vaccine I will receive today.
- I have read and understand the information contained in the EUA for Vaccine recipients or the Vaccine Information Statement.
- I have been given the opportunity to ask questions about the COVID 19 vaccine.
- I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to provide consent.*

Patient's Signature: _____

Date Consent Form Signed: _____

Parent/Legal Guardian Signature* (if patient is under 18)

_____

*If minor is in state custody, an authorized representative signature is required.

Parent/Legal Guardian's Name (please print):

_____

Parent/Legal Guardian's Daytime Phone Number

(If parent/legal guardian will not be present at the clinic.)

_____

For clinic use only:

Date of vax:_____ Site: ☐ LA ☐ RA

Form updated 10/22/21,AAM

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: ○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ 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