MR # DOB

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NAME

DATE

BASSETT HEALTHCARE NETWORK

COVID-19 IMMUNIZATION SCREENING AND CONSENT FORM (UNDER 18 YO)

H-3237 6/21 (d:\forms\hosp\.ofm)

Health Center _____

Recipient Name (please print)	Date of Birth
Phone Number	Medical Record Number (Office use only)
Address	Mother's Maiden Name (First & Last)

SCREENING QUESTIONS

Is your child feeling sick today?	☐ Yes ☐ No	Is your child pregnant or considering becoming pregnant?	☐ Yes ☐ No
In the last 10 days, has your child had a COVID-19 test because they had symptoms and are still awaiting their test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes ☐ No	Has your child ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	☐ Yes ☐ No
Has your child been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did your child receive the last dose? Date:_____	☐ Yes ☐ No	Does your child take any medications that affect their immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have they had any radiation treatments?	☐ Yes ☐ No
Does your child have cancer, leukemia, HIV/ AIDS, a history of autoimmune disease, or any other condition that weakens the immune system?	☐ Yes ☐ No	Does your child have a bleeding disorder, a history of blood clots or is your child taking a blood thinner?	☐ Yes ☐ No
Has your child had ANY vaccines in the past 14 days (2 weeks) including flu shot?	☐ Yes ☐ No	Has your child received a previous dose of the COVID-19 vaccine? If yes, which vaccine? ☐ Pfizer	☐ Yes ☐ No

QUALIFYING ELEMENT

Age 12 & older (Pfizer only)	☐ Yes ☐ No
Would you like to be present when your child receives the Covid Vaccine?	☐ Yes ☐ No Phone number to schedule appointment:_____

Consent: I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination, including that The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). I understand that if this vaccine requires two doses. Two doses of this vaccine will need to be administered (given) in order for it to be effective. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I have read the list of vaccination priority groups above. I hereby certify under penalty of law that I am member of a priority group eligible for vaccination.

_____ _____ _____ _____

Parent/Guardian (Signature) Date Time Print Name

Area Below to be Completed by Vaccinator

Vaccine Name	Dose	Date	EUA Fact Sheet Date	Site	Lot Number:
COVID-19	☐ First ☐ Second			☐ Left ☐ Right Deltoid	
☐ Pfizer 0.3 mL					

I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable). I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Registered Nurse/Practitioner Signature:_____ Date:_____ Time: _____

Vaccinator Signature: _____ Date:_____ Time: _____

CONSENTS