Entered in NYSIIS _____

Children and Adolescents Ages 5-11 years old

Name: _____ **DOB:** _____ **Age:** _____

Address: _____ **Phone:** _____

_____

Parent / Guardian: Place your *initials* on the line to the left of the answer to each of the following

YES	NO	
_____	_____	Are you between the ages of 5 and 11 years old?
_____	_____	Are you 12 years old or older?
_____	_____	Are you feeling sick today?
_____	_____	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your 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?
_____	_____	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days? *If so, when was the last dose?* _____
_____	_____	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing or anaphylaxis, to any vaccine or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?
_____	_____	Do you have a bleeding disorder, a history of blood clots, or are you taking a blood thinner?
_____	_____	Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?
_____	_____	Do you take any medications that affect your immune system, such as cortisone, prednisone, or anticancer drugs, or have you had any radiation treatments?
_____	_____	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?
_____	_____	Have you received a previous dose of the Pfizer, Moderna, or Janssen Vaccine?
_____	_____	Have you received a previous dose of a COVID-19 vaccine authorized by the WHO but not by the FDA (AstraZeneca – VAXZEVRIA, Sinovac – CORONAVAC, Serum Institute of India – COVISHIELD, Sinopharm/BIBP)?

Please acknowledge each of the following with initials: ***(Parent or Guardian please initial)***

_____ I understand the risks and benefits of the vaccine and have received the FDA Fact Sheet.

_____ I have told the vaccination provider about any pertinent medical conditions and have had all of my questions answered to my satisfaction.

Parent/Guardian Information:

_____ _____ _____

Print Name Signature Relationship to Patient

(_____) _____-_____

Phone #

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today? _____

Vaccine Name	Administration	EUA Fact Sheet Date	Manufacturer Lot #
Pfizer/BioNTech	___ First ___ Second __ Third	_____	_____

Administration Site: ___ Left Deltoid ___ Right Deltoid

Dosage: ___ 0.2mL

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Emergency Use Authorization:

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

Health Insurance Information

Health Insurance Carrier/Company: _____

Health Insurance ID#: _____

Health Insurance Group #: _____

Health Insurance Claims Address: _____
(only if carrier is unfamiliar)

_____

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose of the COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years with an underlying medical condition based on individual benefits and risks, 18-64 years and at an increased risk for COVID-19 exposure and transmission because of occupational or institutional setting based on individual benefits and risks) to increase my protection.

I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

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 understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare, or other third parties who are financially responsible for my medical care. 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.

Patient/Surrogate Signature: _____ Date: _____