**DOSE # 1**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Male / Female Weight \_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:** ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian authorized to consent for vaccine: (PRINT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please answer the questions below for the child. If you answer ‘yes’ to any questions, it does not**

 **necessarily mean the vaccine won’t be given. It just means additional questions must be asked.**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Is the child feeling sick today?**
 | ☐ Yes  | ☐ No  | ☐ Don’t Know  |
|  |  |  |  |
| 1. **Has your child ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization?**
* Was this severe allergic reaction after receiving a COVID-19 vaccine?
* Was this severe allergic reaction after receiving another vaccine or injectable medication?
 | ☐ Yes ☐ Yes ☐ Yes  | ☐ No☐ No ☐ No  | ☐ Don’t Know☐ Don’t Know☐ Don’t Know |
| 1. **Check all that apply to the child:**
 |  |  |  |

\_\_\_ Had a severe allergic reaction to something other than a vaccine such as food, pet, venom, environmental or oral medication allergies

\_\_\_ Has a weakened immune system or on a medicine that affects the immune system

\_\_\_ Has a bleeding disorder

\_\_\_ Takes a blood thinner

\_\_\_ Has fainted with an injection in the past

\_\_\_ Has been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

\_\_\_ Has a history of myocarditis or pericarditis

**Vaccination Release**

This Pfizer-BioNTech COVID-19 Vaccine is FDA-authorized under Emergency Use Authorization (EUA) for those 5-11 years of age. I have read or have had explained to me the information in the **VACCINE INFORMATION FACT SHEET FOR RECEIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 5 THROUGH 11 YEARS OF AGE (10-29-21).** I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine. I have the legal authority to consent to the administration of this vaccine to the person named on this form.

**Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

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**Office Use Only**

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| --- | --- | --- | --- |
| Date | Manufacturer | LOT # | EXP. Date |
|  | **PFIZER** |  |  |
| Site | DOSE | Administered By: | IRIS Initial/date |
| **Left** Deltoid / **Right** Deltoid | **0.2ml** |  |  |

Revised 11-16-21

 **DOSE #2**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian authorized to consent for vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Please answer the questions below for the child. If you answer ‘yes’ to any questions, it does not**

 **necessarily mean the vaccine won’t be given. It just means additional questions must be asked.**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Is the child feeling sick today?**
 | ☐ Yes  | ☐ No  | ☐ Don’t Know  |
|  |  |  |  |
| 1. **Has your child ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization?**
* Was this severe allergic reaction after receiving a COVID-19 vaccine?
* Was this severe allergic reaction after receiving another vaccine or injectable medication?
 | ☐ Yes ☐ Yes ☐ Yes  | ☐ No☐ No ☐ No  | ☐ Don’t Know☐ Don’t Know☐ Don’t Know |
| 1. **Check all that apply to the child:**
 |  |  |  |

\_\_\_ Had a severe allergic reaction to something other than a vaccine such as food, pet, venom, environmental or oral medication allergies

\_\_\_ Has a weakened immune system or on a medicine that affects the immune system

\_\_\_ Has a bleeding disorder

\_\_\_ Takes a blood thinner

\_\_\_ Has fainted with an injection in the past

\_\_\_ Has been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection

 \_\_\_ Has a history of myocarditis or pericarditis

 **Vaccination Release**

This Pfizer-BioNTech COVID-19 Vaccine is FDA-authorized under Emergency Use Authorization (EUA) for those 5-11 years of age. I have read or have had explained to me the information in the **VACCINE INFORMATION FACT SHEET FOR RECEIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 5 THROUGH 11 YEARS OF AGE (10-29-21).** I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine. I have the legal authority to consent to the administration of this vaccine to the person named on this form.

**Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

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**Office Use Only**

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| --- | --- | --- | --- |
| Date | Manufacturer | LOT # | EXP. Date |
|  | **PFIZER** |  |  |
| Site | DOSE | Administered By: | IRIS Initial/date |
| **Left** Deltoid / **Right** Deltoid | **0.2ml** |  |  |

 Revised 11-16-21