



Emmet County Public Health

Moderna COVID-19 Vaccine Screening & Consent **6 mo-4 year old**

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.

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

3. 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

The U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, Moderna COVID-19 Vaccine, for active immunization to prevent COVID-19 in individuals 6 months of age and older. 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: _____

Office Use Only

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Emmet County Public Health

Moderna COVID-19 Vaccine Screening & Consent **6 mo-4 year old**

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.

4. Is the child feeling sick today? Yes No Don't Know
5. Has your child ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization? Yes No Don't Know
- Was this severe allergic reaction after receiving a COVID-19 vaccine? Yes No Don't Know
 - Was this severe allergic reaction after receiving another vaccine or injectable medication? Yes No Don't Know

6. 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
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Parent/Guardian Name: _____ Signature: _____ Date: _____

Office Use Only

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| Date | Manufacturer MODERNA | LOT # | EXP. Date |
| Site Left Deltoid / Right Deltoid | DOSE 0.25ml | Administered By: | IRIS Initial/date |