WEISS PEDIATRIC CARE

CHILD COVID-19 VACCINE
SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Child's Name: Last:	**First:**	**Middle Initial:**
D.O.B.	**Age:**	
Name of Legal Guardian: Last:	**First:**	
Mobile Phone Number (Parent/Guardian)		
Do you have active insurance on file with us? If no, please provide current information. If yes, skip to SECTION 2		

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check **YES or No** in response to the following questions regarding your child:	Yes	No
Has today or had at any time in the last 7 days a fever of 100.4+, cough, shortness of breath, difficulty breathing, new loss of taste or smell, or sore throat,		
Tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
Had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
Had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check **YES or No** in response to the following questions regarding your child:	Yes	No
Carries an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines, or latex?		
Is immunocompromised or on a medication that affects the immune system?		
Received a previous dose of any COVID-19 vaccine? If yes, where?		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent/legal guardian of the patient and confirm that the patient is at least 5 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Weiss Pediatric Care to administer the COVID-19 vaccine to my child.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected that my child receive today. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If my child experiences a severe reaction, I will call 9-1-1 or go to the nearest hospital.

Signature of Patient or Authorized Representative_____ Date: _____

Print Name and Relationship to Child Receiving Vaccine: _____

For office use only: **First Dose** _____ **Second Dose** _____ **Temperature** _____