COVID-19 Vaccine Screening Questionnaire for Children 5 through 11 years of age

(ENGLISH)

Complete the Following for the minor patient receiving the Pfizer-BioNTech COVID-19 Vaccine:

Minor Patient Name: First_____ Middle_____ Last_____

Birth Date: _____/_____/_____ Age: _____ Weight: _____ Sex: ☐ F ☐ M Ethnicity: Hispanic/Latino ☐ YES ☐ NO ☐ Not known

Race: (Check all that apply): ☐ White ☐ Black ☐ Asian ☐ Am Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other/Mixed ☐ Unknown

Mailing Address: _____ City/State/Zip: _____ Email: _____

Parent/Guardian Phone: (_____) -_____ - _____ Alternate Emergency Contact & phone _____

Parent/Guardian Consent:

I, _____, hereby attest as follows:
(Printed Name of Person Giving Consent)

1. I am the (Check one): ☐ Parent ☐ Legal Guardian ☐ Other : _____
2. I have the legal authority to make healthcare decisions on behalf of the minor patient named above.
3. I understand that I have the option to accept or refuse Pfizer-BioNTech COVID-19 Vaccine on behalf of the minor patient.
4. I understand this vaccine is offered to all regardless of immigration status. Your information will not be shared.
5. I understand that the U.S. Food and Drug Administration ("FDA") has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine for individuals 5 through 11 years of age. The Pfizer-BioNTech COVID-19 Vaccine is fully approved only for individuals 16 years of age and older.
6. The minor patient is between 5 to 11 years of age.
7. I have been provided access to and read the Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers ("Fact Sheet").
8. I understand there are potential risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine, the extent of which are known and unknown.
9. I understand that the Pfizer-BioNTech COVID-19 Vaccine consists of two doses, spaced approximately 3 weeks apart.
10. I acknowledge I have had the opportunity to ask questions regarding the immunization to be administered to the minor patient.
11. The minor patient and I agree that he/she will remain in the observation area for the required time period following vaccine dose administration
12. Therefore, I hereby consent to the minor patient named above being administered the Pfizer-BioNTech COVID-19 Vaccine. Further, I authorize all medically necessary treatment in the rare event that he/she has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions

Questions Regarding the Minor Patient:

	YES	NO
1. Is the minor patient between 5 to 11 years old?	☐	☐
2. Is the minor patient sick today? If yes, list symptoms: _____	☐	☐
3. Has the minor patient had an allergic reaction to? *(This would include a severe allergic reaction to [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*		
A component of the COVID-19 vaccine, including either of the following:		
* Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparation for colonoscopy procedures?	☐	☐
* Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids?	☐	☐
A previous dose of COVID-19 vaccine?	☐	☐
Another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐

4. Check all that apply to the minor patient:
   - ☐ A female between ages 18 and 49 years old
   - ☐ A male between ages 12 and 29 years old
   - ☐ Has a history of myocarditis or pericarditis
   - ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
   - ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
   - ☐ Was diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Has ever fainted after receiving an injection
   - ☐ Has a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
   - ☐ Is pregnant or breastfeeding
   - ☐ Has a bleeding disorder
   - ☐ Takes a blood thinner
   - ☐ Has a history of heparin-induced thrombocytopenia (HIT)
   - ☐ Has a history of Guillain-Barré Syndrome

I hereby acknowledge that I have had the opportunity to ask questions regarding the immunization to be administered to the minor patient named above. I agree to allow his/her immunization information to be stored and accessed by authorized users in "Nevada's Web IZ". I also agree to have his/her blood tested for blood borne bacteria and viruses that may result in disease in the event a person is exposed to his/her blood or body fluids. By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

Signature: X _____ **Date:** _____

Parent/Guardian signature required if under 18 years old

For Clinic Use Only – Do Not Write Below

VACCINE	CVX	CPT	DATE GIVEN	LOT #	EXP. DATE	RT	SITE	DOSE	CLINIC	ADMINISTERED BY	FACT SHEET DATE
Pfizer (PFR)	218	91307				IM	LD RD	0.2 mL	WCHD		10/2021