CHESTER COUNTY PEDIATRICS PC
690 WEST LINCOLN HIGHWAY
EXTON
PA 19341
(610)873-5437

COVID-19 Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Date of Birth	⌋ Male ⌋ Female ⌋ Other	
Address		City		State	Zip
Phone Number	Email		Name of Primary Care Provider		

SCREENING FOR VACCINATION ELIGIBILITY

1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
4. Are you under age 5?	Yes	No
5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days? (If you answer yes to this question, it is recommended you consult with your physician prior to receiving the COVID-19 vaccine)	Yes	No
10. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/	/
12. If this is your second dose, which vaccine did you receive (Pfizer or Moderna)?		
13. Are you moderately to severely immunocompromised?	Yes	No
14. If this is your third dose, when was the date of your second dose?	/	/
15. If this is your third dose, which COVID-19 vaccine did you receive previously (Pfizer or Moderna only)?		
16. Do you meet any of the following criteria: Age 65 or older; age 18 or older with an underlying medical condition; age 18 or older and work or live in a high-risk or long-term care setting?	Yes	No
17. If this is a booster dose, when was the date of your second dose of the Moderna or Pfizer-BioNTech COVID-19 vaccines or the date of your first dose of the Janssen (J/J) vaccine?	/	/

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the PA-SIIS system for care coordination and to monitor statewide vaccination coverage. Further, I agree that the information above is correct.

Signature of Parent/Guardian/Patient_____Date_____

******FOR OFFICIAL USE ONLY******

DATE GIVEN:_____

Client Name (Last, First, MI)_____

Client DOB M/DD/YYYY)_____

OFFICE USE ONLY - DO NOT WRITE BELOW

Ask before administration:

Is the client suffering from a moderate or sever acute illness with or without fever?
(Circle) **Y** **N**

Is the client pregnant? (Circle) **Y** **N** **NA**

Client completed the manufacturer's screening questions (Circle) **Y** **N**

Vaccine Manufacturer: _____

Lot #:_____

Exp. Date: _____

Site:
___ LT deltoid IM
___ RT deltoid IM
___ OTHER

Dose Number: (Circle) 1st 2nd 3rd 4th 5th

EUA*/VIS given? ___Y ___N

Reaction? ___Y ___N

Vaccination Complete? ___Complete ___Refused ___Not Administered
___Partially Administered ___No recorded completion status

Given By Signature:_____