Covid Vaccine Administration Record and Screening Consent Form

FOR 5-11 YEARS OF AGE

Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) with other healthcare providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary.

Last Name:	**First Name:**		**DOB:**
Phone:	**Email:**		**Age (5-11 ONLY)**
Social Security Number: (optional) will provide you access to your child's record	**City:**	**State:**	**Zip:**

Gender:
☐ Male ☐ Transgender – Male to Female ☐ Transgender – Unspecified or Gender Non-Specific
☐ Female ☐ Transgender – Female to Male ☐ Prefer not to Answer ☐ Other _____

Race: (check all that apply)
☐ Asian ☐ American Indian or Alaskan Native ☐ White
☐ African American or Black ☐ Native Hawaiian or other Pacific Islander
☐ Prefer not to Answer ☐ Other_____ ☐ Multi-race

Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Prefer not to answer

Questions for person receiving vaccine:	**Yes**	**No**
1. Is your child sick today *(fever, cough, shortness of breath, nausea/vomiting in the past 24 hours)*		
2. Is your child currently completing an isolation or quarantine due to COVID-19?		
3. Has your child received a dose of COVID-19 vaccine?		
4. Has your child ever had a severe allergic reaction *(anaphylactic)* to any food, medication, vaccine, or previous COVID-19 vaccine? List:_____		
5. Has your child received antibody therapy of convalescent plasma for COVID-19 treatment in the past 90 days?		

Check all that apply:
☐ My child has a history of myocarditis or pericarditis
☐ My child has been diagnosed with Multisystem Inflammatory Syndrome after a COVID-19 infection
☐ My child has a bleeding disorder and/or takes a blood thinner.

I have been given a copy and have read, or have had explained to me, information about the disease and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of receiving a vaccine approved under an Emergency Use Authorization from the FDA. I understand that if this vaccine requires more than one dose, more than one dose of this vaccine will need to be given in order for it to be effective. I consent that my child receives the vaccine in a public location. I have been made aware of the appropriate time my child is expected to be monitored for post-vaccination reactions based on their risk factors. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to my child.

Parent/Guardian signature _____ Date:_____

Parent/Guardian name (Print)_____Relationship to recipient _____

For Vaccinator			
Vaccine	**Site**	**Signature and Title -- Person Administering Vaccine**	**Date**
COVID-19	**LD RD**		
Trade Name/Manufacturer Lot Number:			