COVID vaccine < 5yo

Recipient Name: First_____Middle_____Last_____

Date of Birth _____/_____/_____ **Recipient Email Address:** _____ ☐ No email

Home Phone Number: _____**Mobile Phone Number:** _____

Address: _____ **City:** _____

Zip Code: _____ **County:** _____**State:** _____

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French ☐ Spanish ☐ Hindi ☐ Other ☐ Decline to state

Insurance: ☐ Medicaid ☐ Private (eg BCBS) ☐ Uninsured

(no out of pocket cost, info for statistics)

I certify that I am able to consent for this COVID19 vaccine against this communicable disease since I am the parent or legal guardian of the above-named patient. I consent for them to receive the vaccine and for demographic info to be shared with the NC Immunization Registry as required. I have received a copy of the Emergency Use Authorization Fact Sheet (QR codes Moderna on top, Pfizer on bottom). 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 I experience a severe reaction after leaving the office, I will call 911 or go to the nearest hospital. I authorize payment from private Insurance or Medicare/Medicaid to be made on my child's behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature below will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to Sandhills Pediatrics. **THE COVID VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL**. If you are not an existing Sandhills Pediatrics patient, we need a copy of your insurance card so we can bill your insurance as required by the government (No out of pocket cost to you by Federal Law!)

Moderna 6mo-5yo

Pfizer 6mo-4yo

Please sign up for the V-SAFE program on your smartphone to help CDC monitor side effects & safety - vsafe.cdc.gov

I would like for my child to receive the COVID vaccine from:

_____Moderna (2 doses 4-8 weeks apart) or _____Pfizer (3 doses- 1st to 2nd dose 3-8 weeks apart; 2nd-3rd 8 wks apart)

Signature _____Date _____

Print name_____ (**Parent/guardian must sign**)

Site of Injection: ☐ Right Delt, IM ☐ Left Delt, IM ☐RAT_____ ☐ LAT____ ☐ 1st dose ☐ 2nd ☐ 3rd

Administration Date: _____/_____/_____ **Time:** _____ ____ Moderna(BlueCap) _____ Pfizer (MaroonCap)

Lot #: _____**Exp:** _____/_____/_____ **Vaccine administered by:**_____

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Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. How old are you? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists