COVID-19 Vaccination Consent Form 2022 Children Under 5 years-old

Last Name *(Please print)*	First Name	MI	Date of Birth	MALE FEMALE

Address	City	State	Zip

Phone Number	Email	Parent/Guardian Name

SCREENING FOR VACCINATION ELIGIBILITY		
1. Is the patient under the age of 5 years-old?	Yes	No
2. Does the patient has a weakened immune system caused by something such as HIV or cancer?	Yes	No
3. Has the patient ever 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
4. Has the patient ever 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
5. Has the patient ever had a positive COVID 19 or has a doctor ever told you the patient had COVID 19? If so what date where diagnosed?____	Yes	No
6. Has the patient received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
7. Does the patient take immunosupressive drugs or therapies?	Yes	No
8. Is the patient currently sick? For example, is the patient currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
9. Has the patient tested positive for COVID-19 in the last 14 days?	Yes	No
10. Is the patient currently in quarantine for COVID-19 exposure?	Yes	No
If this is your second dose, when was the date of your first dose?		

CONSENT FOR VACCINATION

I/Parent/Legal Guardian hereby certify that I'm able to make decision for the patient and the foregoing history is true and complete to the best of my knowlegde. I/Parent/Legal Guardian have received and read the Vaccine Information from the CDC and FDA. I/Parent/Legal Guardian hereby consent to the administration of the COVID-19 vaccine and fully understand the risks and the benefits of the COVID vaccine. By signing below I/Parent/Legal Guardian give Pleasant Pediatrics permission to bill my insurance for the administration of the COVID-19 vaccine and I/Parent/Legal Guardian authorize the release of any medical information necessary to process my claim and payment of benefits. The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient____Date_________________

FOR ADMINISTRATIVE USE ONLY **VIS Date:**

Vaccine	Date Vaccination and EUA Given:	Route IM *R L*	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator