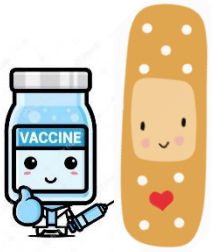
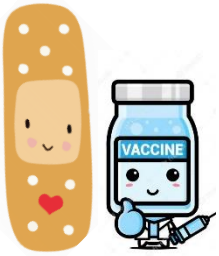


Wood County Health Department

COVID-19 Vaccine Administration Record and Screening for

PFIZER ORANGE CAP

5 YEARS THROUGH 11 YEARS OLD



Information collected on this form will be used to document authorization for receipt of vaccines. The information may be shared through the Wisconsin Immunization Registry (WIR) for the purpose of maintaining a complete, accurate record and with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is confidential. **Please Print.**

Child's Name: Last: | | | | | | | | | | | | | | | First: | | | | | | | | | | | | MI: |

Mother's Maiden Name:_____ **Printed name of person filling out consent**:_____

Age: ____ **Weight (lbs):** _____ **Date of Birth:** m:_____day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

Address:_____ **City:**_____ **Zip:**_____ **Telephone:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Questions for parents consenting their child receive vaccine	**Yes**	**No**
1. Is your child sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Has your child received a previous COVID-19 vaccine? *Be prepared to show card/documentation* Date(s) _____ _____ _____	☐	☐
3. Has your child ever had a **severe allergic reaction that required treatment with epinephrine/EpiPen or that caused you to go to the hospital, or that caused hives, swelling, wheezing, or respiratory distress to any of the following:** • A COVID-19 vaccine component (including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures)? • Polysorbate (which is found in some vaccines, film coated tablets, and IV steroids)? • A previous dose of COVID-19 vaccine, another vaccine, or injectable medication? List: _____ • Anything else (ex. other medication allergies, food, pets, venom, environmental allergies, etc.)? List: _____	☐	☐
4. Has your child been diagnosed with Multisystem Inflammatory Syndrome (MIS-C)? (if yes, *defer vaccination and refer to person's health care provider for further discussion/evaluation.*)	☐	☐
5. Does your child have a history of myocarditis or pericarditis? (if yes, *defer vaccination and refer to person's health care provider for further discussion/evaluation.*)	☐	☐
6. Is your child currently in isolation or quarantine period due to COVID-19?	☐	☐

I have answered the above questions to the best of my knowledge and consent that my child be immunized. I have been given a copy and have read, or have had explained to me, information about the diseases 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 my child receiving a vaccine approved under an Emergency Use Authorization from the FDA. I understand that if my child has had a dermal filler, he/she may experience temporary swelling at or near the site of the filler injection (usually face/lips) and will contact my health care provider if swelling develops. I consent to having my child receive 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 risk factors. If my child is receiving a third dose of vaccine, I attest that he/she is doing so due to having a weakened immune system. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to my child.**

Consent obtained/Signature and relationship to child:_____ **Date:** _____

Are you receiving: PRIMARY SERIES: ☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3 Additional Dose (immunocompromised)**

BOOSTER DOSE: ☐ **Booster dose #1** **(5 months after Dose 2 if not immunocompromised OR 3 months after Dose 3 if immunocompromised)**

For Vaccinator/Office Use (Rev. 6/29/22)

Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date	Dose
COVID-19	RD LD			0.2ml

Signature and Title – Person Administering Vaccine:_____ Date:_____

Entered into WIR by:_____Date:_____