



COVID-19 Vaccine Administration Record & Screening for Pfizer Maroon Cap **6 MONTHS through 4 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 (lb): _____ Date of Birth: m: _____ day: _____ yr: _____ 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)	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child received a previous COVID-19 vaccine? <i>Be prepared to show card/documentation</i> Date(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
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: <ul style="list-style-type: none"> • 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: _____ 	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child been diagnosed with Multisystem Inflammatory Syndrome (MIS-C)? (if yes, <i>defer vaccination and refer to person's health care provider for further discussion/evaluation.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have a history of myocarditis or pericarditis? (if yes, <i>defer vaccination and refer to person's health care provider for further discussion/evaluation.</i>)	<input type="checkbox"/>	<input type="checkbox"/>
6. Is your child currently in isolation or quarantine period due to COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>

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. **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: _____

PRIMARY SERIES: Dose 1 Dose 2 Dose 3

For Vaccinator/Office Use (Rev. 6/29/22)				
Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date	Dose
COVID-19	RD LD RVL LVL			0.2ml
Signature and Title – Person Administering Vaccine: _____ Date: _____				
Entered into WIR by: _____ Date: _____				