ArnotHealth **COVID-19 Patient Information and Vaccination Sheet (Children and Adolescents 5-11 years old)**

Today's Date: _____ **Primary Care Provider:**_____

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**	**Date of Birth:**	**Sex:** ❑ Male ❑ Female ❑ Other
Mailing Address:	**City:**		**State:**	**Zip:**
Patient attends school at:				

PARENT OR LEGAL GUARDIAN CONTACT INFORMATION

Name:		**Relationship to recipient:**	
Home Phone #:	**Cell Phone #:**	**Work Phone #:**	**Email Address:**

Preferred Contact Method (please select only one): ❑ Home Phone ❑ Mobile Phone ❑ Work Phone ❑ Email

Office May Leave Message on Voicemail: ❑ Yes ❑ No

DEMOGRAPHIC INFORMATION

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Decline **Language Preference:** ❑ English ❑ Spanish ❑ Other

PRIMARY INSURANCE COMPANY

Insurance Company:	**Birthdate:**	**Patient's Relationship to Subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other
Subscriber Name:	**Policy ID #:**	
	Group #:	

CONSENT

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses to be considered fully vaccinated. Further, I understand that a booster dose of COVID-19 vaccine may be recommended at least 2 months following the first dose of Janssen vaccine or at least 6 months following the second dose of Pfizer-BioNTech or Moderna COVID-19 vaccine if I am a member of a certain population (e.g., 65 years or older, 18 years old or older and a resident of a long term care facility, 50-64 years with an underlying medical condition, 18-49 years old with an underlying medical condition based on individual benefits and risks, 18-64 years old and at an increased risk for COVID-19 exposure and transmission because of working or living in a high-risk setting and based on individual benefits and risks) to increase my protection.

I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

NEW YORK STATE OF OPPORTUNITY. Department of Health

Print Name:_____ **Date of Birth:**_____

SCREENING QUESTIONS	Yes	No	Unknown
Are you between the ages of 5 and 11 years old?	❑	❑	
Are you feeling sick today?	❑	❑	
In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a health care provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	❑	❑	❑
Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*_____	❑	❑	❑
Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	❑	❑	❑
Do you have cancer, leukemia, HIV/AIDS, or any other condition that weakens the immune system?	❑	❑	❑
Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	❑	❑	❑
Have you received a previous dose of Pfizer vaccine?	❑	❑	
Have you received a previous dose of a COVID-19 vaccine recognized by the WHO but NOT by the FDA (AstraZeneca - VAXZEVRIA, Sinovac - CORONAVAC, Serum Institute of India - COVISHIELD, Sinopharm/BIBP)?	❑	❑	❑

Recipient/Surrogate/Guardian Signature: _____**Date:** _____

Print Name: _____

For Immunizer/Pharmacist use ONLY:

VACCINE ADMINISTRATION INFORMATION

Which vaccine is the patient receiving today?

Vaccine Name	Administration	Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	❑ First Dose ❑ Second Dose		

- I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)
- I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Administration Site: ❑ Left Deltoid ❑ Right Deltoid ❑ Left Thigh ❑ Right Thigh

Dosage: ❑ 0.2 ml

Vaccinator Printed Name: _____

Vaccinator Signature: _____ Date:_____