COVID-19 VACCINE SCREENING AND CONSENT FORM
5 through 11 years of age
PFIZER ADMINISTRATION ONLY

COMMUNITY HEALTH of SOUTH FLORIDA, INC.

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Name: Last:	First:		Middle Initial:	
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian):** ( )			
Address:	**Apt/Room #:**			
City:	**State:**		**Zip:**	
Name of Legal Guardian: Last:	First:		Middle Initial:	
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or other Pacific Islander ☐ White	☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Islander	☐ Unknown
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown				

Primary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company:_____ Insurance Company Phone #_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____
Secondary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company:_____ Insurance Company Phone #_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____

Designation of COVID-19 vaccination dose number? ☐First Dose of ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Does your child have today, or have your child had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have your child tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have your child had a severe allergic reaction (e.g., needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have your child had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	**Yes**	**No**
1. Does your child have any allergies?		
2. Does your child carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
3 Has your child had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?		
4. Is your child immunocompromised or on a medication that affects the immune system?		
5. For girls, Is your child pregnant?		
6. Is your child breastfeeding?		
7.Has your child received another COVID-19 vaccine?		
8. Has your child ever fainted in association with an injection?		
9. Does your child have a bleeding disorder or is on a blood thinner/blood-thinning medication?		
10. If your child is under the age of 18 are you, as guardian, aware that your child is only eligible to receive the Pfizer vaccine?		

- I certify that I am: the legal guardian of the patient and confirm that the patient is less than 12 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Community Health of South Florida (CHI) to administer the COVID-19 vaccine.
- Currently, Pfizer is the only COVID-19 vaccine product that has been fully approved and licensed by FDA. This FDA approval and license is for use in individuals 5 years of age and older only. I understand that this product (other than Pfizer for usage in ages mentioned above only) has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 5- to 11 years old, 12 to 17 years of age (Pfizer only) or 18 years of age and older (Pfizer, Moderna , or Johnson and Johnson) ; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected my child to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location with my child for approximately 15 minutes (or more in specific cases) after administration for observation. If my child experiences a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize CHI to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services.
- I acknowledge receipt of the CHI Notice of Privacy Practices.
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Signature of Authorized Representative_____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: facility name/ID	
Administered at location: Type	
Administration Address:	
CVX (product)	
Sending organization:	

Vaccinator Print Name:_____ **Signature:**_____ **Date:**_____

Vaccine administering provider suffix: _____