MRN:_____

COVID-19 Immunization Screening and Consent Form: *Children and Adolescents Ages 6 Months– 5 Years Old

Recipient Name (please print)	DOB:

Screening Questionnaire				
1.	Are you between the ages of 6 months and 5 years old?	□ Yes	□ No	
2.	Are you feeling sick today?	□ Yes	□ No	
3.	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 toisolate or quarantine at home due to COVID-19 infection or exposure?	□ Yes	□ No	□ Unknown
4.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90days (3 months)? *If yes, when did you receive the last dose? Date:* _____	□ Yes	□ No	□ Unknown
5.	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 asevere allergic reaction (anaphylaxis) to anything?	□ Yes	□ No	□ Unknown
6.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
7.	Do you take any medications that affect your immune system, such as cortisone, prednisone orother steroids, anticancer drugs, or have you had any radiation treatments?	□ Yes	□ No	□ Unknown
8.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis(inflammation of the lining around the heart)?	□ Yes	□ No	□ Unknown
10.	Do you have a history of MIS-C (Multisystem Inflammatory Syndrome in Children)?	□ Yes	□ No	□ Unknown
11.*	Have you received a previous dose of the Pfizer, Moderna, or Janssen vaccine?	□ Yes	□ No	Date: (if applicable)

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 is recommended for those 6 months–4 years of age who received Moderna as a primary series and those 5 years of age and older at least 2 months following the completion of a COVID-19 vaccine primary series or ~~a monovalent~~ booster dose 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 authorizedto 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.

_____

Signature of parent/guardian Date / Time Print Name Relationship to Patient (if other than recipient)

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	Administration				Manufacturer & Lot #	EUA Fact Sheet Date
Moderna	□ First Dose	□ Second Dose	□ Bivalent Booster (6 months–5 years)		MODERNA 201L22A Exp 9/6/23	4/18/23
Administration Site	□ Left Deltoid	□ Right Deltoid	□ Left Thigh	□ Right Thigh		
Dosage	□ 0.2 ml	□ 0.25 ml	□ 0.3 ml	□ 0.5 ml		

□ I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccineand consent to vaccination was obtained.

Vaccinator Signature: _____ Date: _____