Minor Screening and Parental or Guardian Consent for the Pfizer COVID-19 Vaccine

SECTION 1: MINOR VACCINE RECIPIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Date of Birth: _____/_____/_____ Age: ____

Male: ☐ Female: ☐ Other: ☐

Race (check all that apply):

American Indian/Alaskan Native ☐ Asian ☐ African American/Black ☐ White ☐

Native Hawaiian/Pacific Islander ☐ Other Race ☐

Ethnicity:

Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐

SECTION 2: SCREENING QUESTIONNAIRE FOR MINOR TO BE VACCINATED

Do you have a fever today or are you feeling ill?	YES ☐ NO ☐
Have you ever received a dose of a COVID-19 vaccine? If yes, which vaccine product? Pfizer_____ Moderna_____ Another Product_____	YES ☐ NO ☐
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	YES ☐ NO ☐
Was the severe allergic reaction after receiving a COVID-19 vaccine?	YES ☐ NO ☐
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	YES ☐ NO ☐
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES ☐ NO ☐
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Date_____	YES ☐ NO ☐
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	YES ☐ NO ☐
Do you have a bleeding disorder or are you taking a blood thinner?	YES ☐ NO ☐
Are you pregnant or breastfeeding?	YES ☐ NO ☐

SECTION 3: PARENTAL OR GUARDIAN CONSENT

Please review the Pfizer-BioNTech (Pfizer) COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" available at https://www.fda.gov/media/144414/download.

NAME OF MINOR RECEIVING THE VACCINE

DATE OF BIRTH OF MINOR RECEIVING THE VACCINE

I attest that the minor receiving the vaccine is age 5 or above:

☐ Yes ☐ No

In providing my consent below, I agree that I have reviewed and understand the "Fact Sheet for Recipients and Caregivers" and I understand the potential risks and benefits of the Pfizer COVID-19 Vaccine.

I understand I may not be required to accompany the minor named above to their vaccination appointment and that, by giving my consent below, the minor will receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment.

I GIVE CONSENT for the minor listed above to get vaccinated with the two-dose Pfizer COVID-19 Vaccine.

PRINTED NAME OF PARENT OR GUARDIAN

SIGNATURE OF PARENT/GUARDIAN

DATE

RELATIONSHIP TO MINOR