CLARKSVILLE SCHOOL DISTRICT

English

David Hopkins, Ed.D. - Superintendent

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Coronavirus-19 Vaccination Clinic on April 19, 2021

(only for students age 16 and older)

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S C. 1232g; 34 CFR Part 99), I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Pfizer Company, Department of Health, and local Clarksville Family Pharmacy consent forms will be provided for my consideration prior to the clinic.

CLÍNICA DE INMUNIZACIÓN ESCOLAR

Clínica de vacunación Coronavirus-19 el 19 de abril de 2021

(Sólo para estudiantes de 16 años o más)

De conformidad con la Ley del Derecho a la privacidad de la Educación Familiar (FERPA), doy permiso para que mi hijo(a) participe en la Clínica de Vacunación escolar. Tengo entendido que los formularios de consentimiento correspondientes de la Compañía Pfizer, Departamento de Salud y la Farmacia Familiar de Clarksville local se proporcionara para mi consideración antes de la clínica.

Name of Parent/Legal Guardian

(Nombre del Padre de familia / Responsible del menor) ____________________

Minor's First and Last Name ____________________

(Nombre y Apellido del menor)

Parent/Legal Guardian Signature ____________________

(Firma del Padre de familia / Responsable del menor)

Date signed ____________________

(Día firmado)

Clarksville Public Schools does not discriminate on the basis of race, color, national origin, sex, age, qualifying handicap or military status.

COVID-19 Vaccination Consent Form 2020-2021

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female
Address		City	State	Zip
Phone Number	Email	Name of Primary Care Provider		

SCREENING FOR VACCINATION ELIGIBILITY

Question		
1. Are you pregnant?	Yes	No
2. Are you currently breastfeeding?	Yes	No
3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to other vaccines or injectable medications/infusions?	Yes	No
4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?	Yes	No
6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
7. Are you under age 16?	Yes	No
8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
9. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
10. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
11. Are you currently in quarantine for COVID-19 exposure?	Yes	No
12. If this is your second dose, when was the date of your first dose?	/ /	
13. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Guardian Signature for Minor:______________________________ Date:____________

Signature of Parent/Guardian/Patient______________________________ Date____________

FOR ADMINISTRATIVE USE ONLY VIS Date:

Vaccine	Date Vaccination and EUA Given:	Route	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator
COVID 19		IM R L	Pfizer		

Confidential Information Sheet	Your answers to the questions below will allow our pharmacists to maintain your pharmaceutical history properly and will aid in advising you about the medications you are using. *Thank You*		
PLEASE PRINT:	Date:		
LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX ☐ M ☐ F
STREET ADDRESS	CITY, STATE, ZIP		
HOME PHONE	CELL (IF YOU WOULD LIKE TEXT NOTIFICATION)	DATE OF BIRTH	
CONTAINER PREFERENCE ☐ CHILD-PROOF ☐ NON CHILD-PROOF	SOCIAL SECURITY NUMBER		
KNOWN DRUG ALLERGIES			
PHARMACIST'S NOTES:			
Please let us know whenever any of the above data changes. *Thank You*			

Hoja de información confidencial: Historia e información de un estudiante mayor o de 16 años.

Sus respuestas a las siguientes preguntas permitirán a nuestros farmacéuticos mantener su historial farmacéutico correctamente y le ayudarán a informarle sobre los medicamentos que está utilizando.

Gracias.

Apellido del paciente, ______________________, Nombre____________________, Medio inicial______

Género: Hombre___ o Mujer___

Dirección: ____

Ciudad, Estado, Código Postal: ____

Teléfono: ___________________________ teléfono celular: ___________________________________

Fecha de Nacimiento: _____________________ Número de Seguro Social: ________-____-_________

Alergias a los medicamentos (Alergias conocidas a los medicamentos):

Notas del farmacéutico:

Person Receiving Vaccine:

(Legal) First Name: ______________________ MI: ____ Last Name: ______________________

Date of Birth: [ ][ ] [ ][ ] [ ][ ][ ][ ]

1. I have read or had explained to me the Vaccine Information Statements for the two dose series Pfizer vaccine and understand the risks and benefits of this vaccine.

- I give concent to the Clarksville Family Pharmacy and it's staff, partnering with the Arkansas Health Department and Clarksville School District, to give Pfizer Covid-19 vaccine to my child named below that is 16 years of age or over.
- I understand that information about this Covid-19 Vaccinaattionin will be included in the Arkansas Department of Health's Immunization Registry.

2. To my Insurance Carrier (s):

- I authorize the release of any medical information necessary to process my insurance claim (s).
- I authorize and request payment of medical benefits directly to Clarksville Family Pharmacy.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that the photocopy of this form may be used instead of the original.

3. **PATIENT INFORMATION:**

(Legal) First Name: ______________________ MI: ____ Last Name: ______________________

Date of Birth: [ ][ ]/[ ][ ]/[ ][ ][ ][ ] Gender: ☐ Male ☐ Female Phone #: ______________

Street Address: ______________________ P.O. Box ________ Apt. No. ________

City: ______________________ State: ________ Zip Code: [ ][ ][ ][ ][ ]

4. **INSURANCE STATUS** (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

☐ Medicaid/ARKids Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

☐ Medicare Number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

☐ Insurance Company Name: ______________________

Member ID/Policy #: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

REQUIRED POLICY HOLDER Information:

(Legal) First Name: ______________________ MI: ____ Last Name: ______________________

Policy Holder Date of Birth: [ ][ ] /[ ][ ] /[ ][ ][ ][ ] Email Address: ______________________

Policy Holder's Employer Name: ______________________