Bronson COVID-19 Vaccine Consent Form: Minors

Patient Name:

Last: _____First_____Middle_____

Date of Birth: _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Race: ☐ African American or Black ☐ American Indian

☐ Alaskan Native ☐ Asian ☐ White ☐Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Date of Birth must be on or before today's date in **2005** for **Pfizer** _____

COVID -19 Screening Questions (Circle Yes or No)

Yes No Have you had a severe or immediate allergic reaction to a vaccine, vaccine components, or medicine you got from an injection?

Yes No Have you ever had an allergic reaction to a component of the COVID-19 Vaccine, such as polyethylene glycol, polysorbate, or a previous dose of the COVID19 vaccine?

Yes No Have you ever had a severe allergic reaction to any substance that resulted in problems breathing, facial swelling, use of epinephrine, or a hospital visit?

Yes No Have you been given monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the last 90 days?

Yes No Have you received or do you plan to get any other vaccines within 14 days of getting your COVID-19 vaccine?

Yes No Are you pregnant?
If yes, have you consulted with your healthcare provider about receiving the COVID-19 vaccine? Yes No

Continued on opposite side.

To be completed by clinical staff:

Clinical Reviewer: _____ **Date & Time:** _____

Approved to receive vaccine: ☐ **Yes** ☐ **No** **Observation:** ☐ **15min** ☐ **30 min**

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