

COVID-19 Pfizer Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
STUDENT'S DOCTOR'S NAME (Last, First)		Address		City	Zip
SCHOOL NAME		HOMEROOM TEACHER'S NAME		GRADE	

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if your child can get the COVID-19 vaccine. If you answer "NO" to all of the following questions, your child can probably get the COVID-19 vaccine. If you answer "YES" or DON'T KNOW to one or more of the following questions, your child may be able to get the COVID-19 vaccine, but we will contact you to discuss your options. Please mark YES, NO, or DON'T KNOW for each question.

	YES	NO	DON'T KNOW
1. Has your child ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">●Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">●Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.</div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">●A previous dose of COVID-19 vaccine.</div> <div style="border: 1px solid black; padding: 5px;">●A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.</div>			
2. Has your child ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
3. Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? (This would include food, pet, venom, environmental, or oral medication allergies.)			
4. Has your child received any vaccine in the last 14 days?			
5. Has your child ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
6. Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			

7. Does your child have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Does your child have a bleeding disorder or are you taking a blood thinner?			
9. Is your child pregnant or breastfeeding?			
10. Does your child receive frequent lip or face dermal fillers?			

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the COVID-19 Pre-vaccination Checklist and understand the risks and benefits. Please check one of the boxes below, then sign and date.

☐ **I GIVE CONSENT** to the FRUTH PHARMACY and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then your child will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to the FRUTH PHARMACY and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____

Date: month _____ day _____ year _____



2021 COVID-19 Vaccine Consent

Name: _____

Address: _____

Email: _____

Phone: _____

Date of Birth: _____

A record of this immunization may be released to your physician as required by state law.

Affix Prescription Label Here

Vaccine Name: (Circle)

Pfizer – Moderna – AstroZenica

Lot #: _____ Exp.: _____

Arm Administered: LEFT RIGHT

EUA Patient Info Given to Patient: YES

Have you previously received the COVID-19 vaccine?	YES	NO
Have you had a severe allergic reaction after receiving the COVID-19 Vaccine?	YES	NO
Have you ever had a reaction to any component or ingredient of the COVID-19 vaccine?	YES	NO
Have you ever had a severe allergic reaction to any other vaccine or injection?	YES	NO
Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
Are you immunocompromised?	YES	NO
Do you have a fever?	YES	NO
Are you feeling sick?	YES	NO
Are you pregnant?	YES	NO
Could you become pregnant in the next several weeks?	YES	NO
Are you breastfeeding (nursing)?	YES	NO

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid, or other third party payer as needed and request payment of authorized benefits be made on my behalf to Fruth Pharmacy, Inc.

- I confirm the information is accurate.
- I acknowledge that if my Insurance does not cover the cost of administering the vaccine to the pharmacy, that payment must be made at the time of administration of the vaccine.
- I acknowledge that my vaccination records may be shared with federal, state, or local agencies for registry reporting.
- I acknowledge that patients should remain in the waiting area for 30 minutes post administration.
- I acknowledge receipt of Fruth Pharmacy's Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization/vaccine does not substitute for an annual check-up with primary care physician.
- I have read, or have had read to me the EUA Fact Sheet(s) for COVID-19 administration. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Fruth Pharmacy, Inc., its affiliates, officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Signature: _____

Date: _____