Pfizer 5-11Y COVID Vaccine

Consent and Administration Record –COVID-19 Vaccine

Name of my Child's School: _____Grade: _____Classroom/Teacher: _____

Check the box for your child to receive both doses of the Pfizer 5-11Y vaccine.

☐ **Pfizer 5-11Y COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

Information about Student Receiving Vaccine(s) – Please Print			
Student Last Name:	**First Name:**		**MI:**
Street Address:	**City:**	**State:** WI	**Zip:**
Date of Birth (MM/DD/YY):	**Age:**	**Mother's Maiden name**	

Gender:
☐ Male ☐ Transgender – Male to Female ☐ Transgender – Female to Male
☐ Female ☐ Transgender – Unspecified or Gender Non-Specific ☐ Prefer not to Answer ☐ Other _____

Race: (check all that apply)	**Ethnicity**
☐ Asian ☐ American Indian or Alaskan Native ☐ White	☐ Hispanic
☐ African American or Black ☐ Native Hawaiian or other Pacific Islander	☐ Non-Hispanic
☐ Prefer not to Answer ☐ Other_____ ☐ Multi-race	☐ Prefer not to Answer

Parent / Legal Guardian Last Name:	**First Name:**	**Phone Number:** (Where you can be reached on date of clinic)

	The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety. **Questions about the student receiving vaccine:**	**Yes**	**No**
1	Is the student currently in isolation or quarantine period due to COVID-19?		
2	Has the student ever received a dose of COVID-19 vaccine?		
3	Has the student ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? (Please see EUA for complete ingredient list of this vaccine) List:_____		
4	Has the student received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
5	Has the student received any vaccines in the past 14 days?		

CONSENT FOR VACCINATION: I certify that I am: the legal guardian of the patient or a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. I have read, or have had explained to me, the COVID-19 Vaccine Emergency Use Authorization (EUA). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for 15-30 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims where known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I understand that a record of this immunization may be shared through the Wisconsin Immunization Registry (WIR) and with other health care providers directly involved with the vaccinated person's care. I authorize use of this consent to be utilized for multiple dose vaccine(s).

_____ _____
Signature of Parent/Legal Guardian Date Signed

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Child

For Office Use Only

Date	Dose	Vaccine	Lot Number	Expiration Date	Site	Signature & Title – person administering vaccine
	☐ 1ST Dose	Pfizer COVID-19 5-11y 0.2 mL IM	☐ See Cold Chain	☐ See Cold Chain	☐ RD ☐ LD	
	☐ 2nd Dose	Pfizer COVID-19 5-11 y 0.2 mL IM	☐ See Cold Chain	☐ See Cold Chain	☐ RD ☐ LD	

Comments: _____
_____
_____
_____