PHN____ Vaccination Date_________________

COVID-19 Vaccine: Consent and Screening Form for minors age 6 months and through 17 years

SECTION 1: INFORMATION ABOUT MINOR CHILD TO RECEIVE VACCINE (PLEASE PRINT)

MINOR'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S DATE OF BIRTH** (MM/DD/YEAR):	
MINOR'S RACE ☐White ☐Black ☐ Asian ☐Native American or Alaska Native ☐Native Hawaiian or Pacific Islander			**ETHNICITY** ☐Hispanic ☐Non-Hispanic	**Is Minor a person with a disability?** ☐Yes ☐No
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(Middle Initial)	**MINOR'S AGE**	**MINOR'S SEX** ☐Male ☐Female
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER AND MOBILE NUMBER:**	
CITY	**STATE**	**ZIP**	**PARENT/GUARDIAN EMAIL:**	

Primary Insurance Plan Name:_________________________________ Policyholder Name ___________________________________

Member or Policy Number:____________________ Policyholder relationship to the patient:_________________________________

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY: To help determine if your child should not get the COVID-19 vaccine.

	YES	NO	UNKNOWN
1. Is your child currently feeling sick or ill?			
2. Has your child ever received a dose of the COVID-19 vaccine? If yes, which vaccine? ☐ Pfizer-BioNTech ☐ Moderna 3. ☐ Another brand of vaccine: _________________ Date: ___________ 4. How many doses has your child received? ____________			
5. Does your child have a health condition or is undergoing treatment that makes them moderately or severely immunocompromised? *(This would include, but not be limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), or moderate or severe primary immunodeficiency.)*			
6. Has your child ever had a severe allergic reaction that required treatment with epinephrine or EpiPen® or that caused them to go to the hospital? *(This would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)* • A component of a COVID-19 vaccine? • A previous dose of COVID-19 vaccine?			

7. Has your child ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) 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 caused hives, swelling, or respiratory distress, including wheezing.)*			

Check all that apply to your child:

☐Has a history of myocarditis or pericarditis
☐Has a history of thrombosis with thrombocytopenia syndrome (TTS)
☐Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐Has a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
☐Has a history Guillain-Barre syndrome (GBS)
☐Has a history of COVID-19 disease within the past 3 months?

SECTION 3: INFORMATION ON THE RISKS AND BENEFITS OF COVID-19 VACCINES

COVID-19 Vaccines may prevent the individual vaccinated from getting COVID-19. The U.S. Food and Drug Administration (FDA) has authorized the emergency use of certain COVID-19 Vaccines to prevent COVID-19 in individuals 6 months through 17 years under an Emergency Use Authorization (EUA), and has approved the Pfizer/BioNTech's *COMIRNATY (COVID-19 VACCINE, mRNA)* for ages 16 and above. For information about each vaccine and its side effects and possible allergic reactions, see this FDA website:

Multilingual COVID-19 Resources | FDA

SECTION 4: Type(s)/Brand(s) of COVID-19 Vaccine that I authorize the above-named minor child to receive:

[Parent/Guardian to circle one or more] *Pfizer-BioNTech/Comirnaty* *Moderna*

SECTION 5: CONSENT I have reviewed the information on risks and benefits of the COVID-19 Vaccine (Section 3, above) and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent and screening form.
2. I have read or had read to me the age-applicable *Fact Sheet for Recipients and Caregivers*, as posted at **Multilingual COVID-19 Resources | FDA**, for each of the types/brands of COVID-19 Vaccine(s) the minor child named above is being authorized to receive, as noted in Section 4 above.
3. I have the legal authority to consent to have the minor child named above vaccinated with the COVID-19 Vaccine.
4. I am not required to accompany the child named above to their vaccination appointments and that, by giving my consent below, the child may receive the COVID-19 Vaccine whether or not I am present.
5. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the COVID-19 Vaccine. The government is paying for the actual vaccine, and I will not be billed for that portion of the cost of my immunization.
6. I understand that pursuant to state law, all immunizations will be inputted to the Louisiana Immunization Network (LINKS) registry operated by the Louisiana Department of Health.

I GIVE CONSENT to ____ [INSERT VACCINATING ENTITY NAME] to vaccinate the minor child named at the top of this form with the COVID-19 Vaccine and have reviewed and agree to the information included in Section 4 of this form.

Date: month ____ day _____ year ______

Signature of the Parent/Legal Guardian (named above): ____

Manufacturer	Lot#	Expiration Date	Route	Dose	Injection Site	EUA Date	Current reported weight

Entered into LINKS (initial and date) _________________________Notes/Comments: ______________________________________

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