COMMUNITY HEALTH ALLIANCE

COVID Vaccine Informed Consent (Ages 5-11) PEDIATRIC PFIZER

Patient Information

First Name: _____ Last Name: _____

Street: _____

Date of Birth: _____

Age: _____ ***MUST BE 5-11**

City: _____ Zip Code: _____ Phone: _____ **Circle one**: Male Female

Insurance Information

Insurance Name: _____ BIN Number: _____ PCN Number: _____

ID Number: _____ Group Number: _____

☐ I do not have insurance at this time.

Citizenship/immigration documentation and health insurance are not required for a vaccine.

Pfizer Series Information

Are you here to receive:
☐ **DOSE 1** Date of DOSE 1: ___/___/___
☐ **DOSE 2** Date of DOSE 2: ___/___/___
☐ **BOOSTER** Date of Booster: ___/___/___

*Bivalent booster may only be received 2 months after last booster dose.

Screening Questionnaire

	Yes	No
Is your child sick today? If yes, list symptoms: _____	☐	☐
Has your child or anyone in your household been exposed to, diagnosed with, or has been placed in quarantine for COVID-19 in the past 14 days?	☐	☐
Has your child received any vaccinations in the past 2 weeks? If yes, please list: _____	☐	☐
Has your child ever had a severe allergic reaction (anaphylaxis) to any medications, latex, foods, pets or insects that required the use or treatment with epinephrine (EpiPen)? If yes, please list allergies: _____	☐	☐
Does your child have an underlying medical condition like liver, kidney, heart disease, diabetes, or is immunocompromised?	☐	☐
Does your child have a bleeding disorder or take a blood thinner?	☐	☐

I, the undersigned, hereby acknowledge that I have received the Emergency Use Authorization (EUA) vaccine sheet. I have had the opportunity to ask questions for the immunization to be administered to me or the person named above, for whom I am authorized to make this request. I agree to allow my immunization information to be stored and accessed by authorized users in Nevada's WebIZ. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this document, I declare that the above information is true and accurate to the best of my knowledge. By signing this form, I am indicating that I understand that I can access a copy of Community Health Alliance's Notice of Privacy Practices related to health information by visiting https://www.chanevada.org/patients/privacy-policy.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Parent or Legal Guardian Signature: _____ Date: _____

Parent or Legal Guardian Full Name (printed): _____

Vaccine	Lot #	Exp Date	Route	Site	Dose	Date Given	Administered by:
Pediatric Pfizer Monovalent			**IM**	**LD or RD**	**0.2 ml**		
Pediatric Pfizer Bivalent			**IM**	**LD or RD**	**0.2 ml**		

□ Entered into WebIZ

Updated November 2022