 PHN____ **Vaccination Date_____________**

Pfizer-BioNTech COVID-19 Vaccine

Consent and Screening Form for Individuals 6 months through 4 years of age

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

MINOR'S NAME (Last)	(First)	(M.I.)	**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)	(M.I.)	**MINOR'S AGE:**	**MINOR'S SEX: M / F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER AND MOBILE NUMBER:**	
CITY	**STATE**	**ZIP**	**PARENT/GUARDIAN EMAIL ADDRESS:**	

Primary Insurance Plan Name:______________________________________ Policyholder Name ____________________________

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

SECTION 2: SCREENING FOR VACCINE ELIGIBILITY The following questions will help determine if there is any reason your child should not get the COVID-19 vaccine. **If you answer "yes" to any question, it does not necessarily mean that your child should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	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; 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 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 caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including any of the following:			
• 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.)*			

8. 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?

<u>SECTION 3: INFORMATION ON THE RISKS AND BENEFITS OF THE *PFIZER-BIONTECH COVID-19 VACCINE*</u> The *Pfizer-BioNTech COVID-19 Vaccine* may prevent the individual vaccinated from getting COVID-19. The U.S. Food and Drug Administration (FDA) has authorized the emergency use of the *Pfizer-BioNTech COVID-19 Vaccine* to prevent COVID-19 in individuals six (6) months to four (4) years of age under an Emergency Use Authorization (EUA). Said vaccine is administered as a 3-dose series, into the muscle. The initial two (2) doses are administered 3 weeks apart followed by a third dose administered at least 8 weeks after the second dose.

The *Pfizer-BioNTech COVID-19 Vaccine* may not protect everyone. Side effects that have been reported include Severe allergic reactions, Non-severe allergic reactions such as rash, itching, hives, or swelling of the face, Myocarditis (inflammation of the heart muscle), Pericarditis (inflammation of the lining outside the heart), Injection site pain/tenderness, Tiredness, Headache, Muscle pain, Chills, Joint pain, Fever, Injection site swelling, Injection site redness, Nausea, Feeling unwell, Swollen lymph nodes (lymphadenopathy), Decreased appetite, Diarrhea, Vomiting, Arm pain, Fainting in association with injection of the vaccine, and Irritability. There is a remote chance that the *Pfizer-BioNTech COVID-19 Vaccine* could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the *Pfizer-BioNTech COVID-19 Vaccine.* For this reason, a vaccination provider will ask the person receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, a bad rash all over the body, and dizziness and weakness.

<u>SECTION 4: CONSENT</u> I have reviewed the information on risks and benefits of the *Pfizer-BioNTech COVID-19 Vaccine* in 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 latest (i.e. most recently released) version of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 6 MONTHS THROUGH 4 YEARS OF AGE, available at https://www.fda.gov/media/144414/download.
3. I have the legal authority to consent to have the minor child named above vaccinated with the *Pfizer-BioNTech COVID-19 Vaccine*, which consists of an initial two (2) doses administered 3 weeks apart followed by a third dose administered at least 8 weeks after the second dose.
4. I understand that 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 *Pfizer-BioNTech COVID-19 Vaccine* whether or not I am present at the vaccination appointments.
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 *Pfizer-BioNTech COVID-19 Vaccine*. The government is paying for the actual *Pfizer-BioNTech COVID-19 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. More information about LINKS can be found at https://ldh.la.gov/index.cfm/page/3660.

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

____ **Date signed**: month ____ day _____ year ______
Signature of the Parent/Legal Guardian named above

Manufacturer	Lot #	Expiration Date	Route	Dose	Injection site	EUA Date	Current reported weight
Pfizer-BioNTech (6 months-4 years)			Intramuscular (IM)	0.2mL			kg

Entered into LINKS (initial and date)________________________________Notes/Comments: ______________________________________ rev. 6/24/2022