COVID-19 Vaccine
Pediatric Consent Form

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Parent/Guardian: Answer the following questions to help us safely give your child COVID-19 vaccine. Vaccine is free. No ID or insurance required.

Child Information				
Last name	First name		Middle initial	Phone number
Mailing address	City		State	Zip code
Email address	Birthdate	Age	Do you have health insurance? ☐ Yes ☐ No	
Race (check all that apply) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____ ☐ Decline to answer	Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Decline to answer	Sex assigned at birth ☐ Female ☐ Male	Gender identity ☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Genderqueer/non-binary ☐ Other_____	

Parent/Guardian Signature

I have received, read/had explained to me, and understand the COVID-19 vaccine emergency use authorization (EUA) information sheet. I am the parent or legal guardian of the above child, I have authority to make healthcare decisions for the child, and I give my permission for the child to receive COVID-19 vaccine. I understand the benefits and risks of COVID-19 vaccine. I understand my child's immunization information will go into a database other medical providers and school staff use.

Parent/Guardian name (printed)	Parent/Guardian signature	Date
Phone number	Email address	

For office use only				
Dose _____ ml IM	Site ☐ RA ☐ LA	Manufacturer	Lot #	Exp
Date EUA info sheet given	Date EUA published	Appointment? ☐ Yes ☐ No		Appointment date
Vaccinator name (printed)	Vaccinator signature			Date

Prevaccination Checklist for COVID-19 Vaccination

Name

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today. **If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given.** It just means additional questions may be asked. If a question is not clear, please as the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated?			
2. Is the person to be vaccinated sick today?	☐	☐	☐
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	☐	☐	☐

- If yes, which vaccine product was administered?

☐ Pfizer-BioNTech ☐ Janssen *(Johnson & Johnson)* ☐ Another Product
☐ Moderna ☐ Novavax

- How many doses of COVID-19 vaccine were administered? _____
- Did you bring the vaccination record card or other documentation? ☐ ☐

4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? *This would include, but not 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.*	☐	☐	☐
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Has the person to be vaccinated 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	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Has the person to be vaccinated 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 the person to be vaccinated:

☐ Have a history of myocarditis or pericarditis

☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?

☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)

☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)

☐ Have a history of Guillain-Barré Syndrome (GBS)

☐ Have a history of COVID-19 disease within the past 3 months?

☐ Vaccinated with monkeypox vaccine in the last 4 weeks?

Form reviewed by **Date**