Child 5-11 years of age COVID-19 Vaccine Consent Form

Your child is receiving Pfizer vaccine

I have been given a copy and read or have had explained to me the information in the Emergency Use Authorization (EUA) or Vaccine Information Statement (VIS) of the COVID-19 Vaccine that my child will be receiving. I understand the benefits and risks of the vaccine and request that the immunization be given to the person named below for whom I am authorized to make this request.

I agree to remain at the vaccination site for at least 15 minutes following the immunization.

I also understand that the information collected on this form will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure continuation of health care services.

Child's Name (Last)	(First)	(M.I.)	**Child's Age**	**Date of Birth**
Parent's/Legal Guardian's (Last)	(First)	(M.I.)	**Child's Gender** ____M ____F	
Phone Number	**Email Address**			
Address	**State**	**Zip Code**	**County**	
Ethnicity (check one) ____ Hispanic _____ Non-Hispanic	**Race (check one)** ____ African American ____ Asian ____ Native American ____White ____ Other			

Screening Questions for person receiving vaccine: If you answer "Yes" to any question 1-4, please call Pierce County Public Health or your health care provider, you may have to delay your child's vaccination.

Please mark YES or NO for each question.	**YES**	**NO**
1. Is your child feeling sick today?		
2. Is your child under 5 years of age or over 11 years of age?		
3. Does your child have a severe allergic reaction to: Any component of a COVID-19 vaccine as listed in the EUA provided to you?		
4. Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If so, date received: _____		
5. *Has your child had an allergic reaction to a vaccine or injectable therapy? (you will be asked to stay for 30 min)		
6. *Does your child have any other serious allergies? Please list:		
7. *Is your child immunocompromised or on a medication that affects your immune system?		

CONSENT FOR CHILD'S VACCINATION:

I GIVE CONSENT to the Pierce County Public Health Department and its staff for my child named at the top of this form to be vaccinated.

Signature of Parent/Legal Guardian _____ Date: _____

----------**For Office Use Only**----------

Date Vaccine Administered: _____

Vaccine	**Site**	**Manufacturer**	**Dose**	**Lot Number**
COVID-19	RD LD	Pfizer	0.2 ml	FK5127

Signature and Title of Vaccine Administrator: _____