WAIMĀNALO HEALTH CENTER

Consent for Pfizer-BioNTech COVID-19 Vaccines

Ages 5-11 (Orange Cap 0.2mL Dose)

Minor Last Name:		**First Name:**		**M.I.**
Minor DOB:	**Age:**	**Weight:**	**Gender: M/F**	
Parent/Guardian Last Name:		**First Name:**		
Relationship to patient:		**Parent/Guardian Phone Number:**		
Minor's Primary Care Provider:		**Phone Number (if not WHC):**		

I have reviewed and completed the Pre-vaccination Checklist for COVID-19 Vaccines for my child.
I have received and read the VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 5 THROUGH 11 YEARS OF AGE. I understand the risks and benefits and give consent for my child to receive the Pfizer COVID-19 vaccine. In addition, I have received information regarding the Hawaii Immunization Registry (see attached).

I affirm that I am the parent or legal guardian of the child named at the top of this form.

Parent/Guardian Signature: _____ Date:_____

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

If you answer "yes" to any questions, it does not necessarily mean you 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.

Screening Questionnaire: please circle response below

1. Are you feeling sick today? *If Yes, please call back to schedule when the illness has improved. If patient has current COVID-19 infection, patient will need to call back after isolation is over.*	**Yes**	**No**	**Don't know**

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1. Have you ever received a dose of Pfizer COVID-19 vaccine? **a. If yes, Where? _____** **b. Date of dose 1_____** **c. Date of dose 2_____** **d. Did you bring your vaccination record card or other documentation?** Yes No *Pfizer booster approved for ages 12+.* *Moderna booster approved for ages 18+.*	**Yes**	**No**	**Don't know**
2. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), DiGeorge syndrome or Wiskott-Aldrich syndrome) *A Third Dose of Pfizer is for children ages 5-11 with moderately to severely compromised immune systems that can be administered at least 28 days after the second dose of Pfizer. Please note this is different than a booster dose.*	**Yes**	**No**	**Don't Know**

3. Have you ever had an allergic reaction to (see list below): (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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) *If yes to any of the below, STOP and do not proceed. Vaccine is contraindicated.*			
a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	**Yes**	**No**	**Don't know**
b. Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	**Yes**	**No**	**Don't know**
c. A previous dose of COVID-19 vaccine	**Yes**	**No**	**Don't know**
4. Have you 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	**Yes**	**No**	**Don't know**

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include an allergic rection that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. *If yes, inform patient he/she will be observed for 30 minutes after vaccination. If patient has questions, should be referred to Provider.* **RN: counsel patients about unknown risks vs benefits of vaccination, refer patient to Provider if further discussion needed. Observe for 30 mins after vaccination.*			
5. Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? *If yes, should refer patient to Provider prior to scheduling. Consider delaying vaccine until recovery from infection and 90 days after date of diagnosis.*	**Yes**	**No**	**Don't know**
6. Have a history of myocarditis or pericarditis? *If yes, should refer patient to Provider. People who develop myocarditis or pericarditis after a first dose of an mRNA COVID-19 vaccine should defer receiving the second dose.* *If patient has a history of myocarditis or pericarditis unrelated to mRNA COVID-19 vaccination, may receive any FDA-authorized COVID-19 vaccine after episode has completely resolved.*	**Yes**	**No**	**Don't know**
7. Check all that apply to you: □ **Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies** *(30 min observation)* □ **Take immunosuppressive drugs or therapies** □ **Have a bleeding disorder** □ **Take a blood thinner** □ **Have a history of heparin-induced thrombocytopenia(HIT)** □ **History of Guillain-Barre Syndrome (GBS)**			

For Office Use Only:

Date/time given: _____

From reviewed/Administered by:_____ Observed for 15 minutes/30 minutes. Pt Initials:_____

Pfizer Orange Cap Vaccine 0.2mL Dose: 1 2 3 Site: RD LD

Vaccine Name/Lot #/Expiration/Dose/Route: **Place Sticker Here*