COVID-19 VACCINATION SCREENING
Age 17 & Younger

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ PHONE #: _____

ADDRESS: _____

_____

GENDER: _____ ETHNICITY: Hispanic / Non-Hispanic

RACE: African American or Black White Multiracial Asian Native American or Alaskan

Native Hawaiian or Pacific Islander Declined

Are you feeling sick today? **Y / N**

Have you ever received a dose of COVID-19 vaccine? **Y / N**

If yes, which vaccine did you receive? **Pfizer / Moderna / J&J**

Have you ever had an allergic reaction any medications/foods/injections or to any component of this vaccine? (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.) **Y / N**

If yes, please wait for 30 minutes in observation area.

Have you had COVID-19? **Y / N**

If yes, when did you have COVID-19? _____ If you were treated with monoclonal antibodies or convalescent serum, it recommended you delay vaccination for 90 days. If you were diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection, it is recommended that you be fully recovered before receiving COVID-19 vaccination.

TO BE COMPLETED BY IMMUNIZER:

VACCINE: PFIZER LOT #: _____ EXP DATE: _____

DOSE: 0.3ml ROUTE: Intramuscular _____ L Deltoid _____ R Deltoid

ADMINISTERED BY: Signature _____

Printed Name _____

Date: _____

COVID-19 Vaccination Consent

Age 17 & Younger

Must be signed by parent or legal guardian

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ PHONE #: _____

By signing this form, I attest that I am the custodial parent or legal guardian of the above named minor and give my permission for the Pfizer-BioNTech COVID-19 VACCINE to be administered to them. Further, I agree that I have read the information about the vaccination, or someone has explained it to me. I understand the risks and benefits of having my child vaccinated and any questions I had about COVID-19 vaccination have been answered. I hereby release Chester Upland School District and the vaccinator from any and all liability associated with administration and potential side effects of the vaccine. I understand that my child should receive 2 doses of this vaccine to be considered fully vaccinated and protected from COVID-19. This vaccination information will be uploaded to PA Dept of Health immunization registry. The signature below indicates my request and consent for the COVID-19 vaccination to be administered to the above named minor.

Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian: _____

Relationship to Minor (Mother, Father, Legal Guardian): _____

DATE: _____