COVID-19 VACCINE 12+ CONSENT FORM

Consent to Administer COVID-19 vaccine

For Administrative Use:

☐ Second Shot
☐ Walk in

Dayton Children's Hospital will offer a 2-dose COVID-19 vaccine to ages 12+

PLEASE PRINT PATIENT INFORMATION			
PERSONS NAME (Last Name)	**(First Name)**	**(M.I.)**	**Patient Age** ☐ Age 12-17 ☐ Age 18+ 12-17 18 or over
Date of Birth:	**Sex:** ☐ Male ☐ Female ☐ Other	**Ethnic Group:** ☐ Hispanic ☐ Non-Hispanic	Parent/Guardian (if different than patient):
Race: ☐ Alaskan Native ☐ AM-American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Prefer Not to Disclose ☐ Unknown			
Street Address: **Apt #:**	**City:**	**State:** **County:**	**Zip Code:**
Home Phone:	**Alternate/Cell Phone:**	**Email Address:**	

PRESCREENING QUESTIONS:

1.	Do you feel sick today?	☐ Yes	☐ No
2.	Have you had any type of vaccination in the last two weeks?	☐ Yes	☐ No
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, Environmental, or oral medication allergies.	☐ Yes	☐ No
4.	Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ Yes	☐ No
5.	Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ Yes	☐ No
6.	Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ Yes	☐ No
7.	Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ Yes	☐ No
8.	Do you have any serious health conditions (often called co-morbidities)?	☐ Yes	☐ No
9.	Do you have a weakened immune system (i.e., from HIV or cancer) or are you on immunosuppressive drugs?	☐ Yes	☐ No
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No
11.	Are you pregnant or breastfeeding?	☐ Yes	☐ No
12.	Do you have dermal fillers?	☐ Yes	☐ No

If you answered "Yes" to questions 1, 2, or 7 you will not be able to get the COVID vaccine at this time. If you answered "Yes" to questions 3 or 4 you will be observed for 30 minutes. If you answer "Yes" to any other questions we recommend that you consult with your Primary Care Provider before receiving the vaccine.

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Authorization and Consent for Covid-19 Vaccine:
The Food and Drug Administration has authorized the emergency use of the COVID-19 vaccine to prevent COVID-19. I have had a chance to ask questions about the vaccine.

I voluntarily consent and allow Dayton Children's Hospital, hereafter referred to as "DCH" to give the 2 dose COVID Vaccine. The second dose must be given 21 days after the first dose is received. Your child will get their second dose at the same place they got their first dose.

I understand I will be offered the Manufacturer Vaccine information sheet after my child gets the vaccine. Any questions I have about the COVID-19 vaccine can be answered by the Dayton Children's COVID-19 hotline team by calling 1-888-746-KIDS (5437).

Disclosure to Government Authorities: I acknowledge that my child's vaccine record, and associated information may be shared with appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

Release: To the fullest extent permitted by law, I hereby release, discharge and hold harmless DCH, including, without limits, any of its officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my child's COVID-19 vaccine or the disclosure of my child's COVID-19 vaccine records.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form and consent to the COVID-19 vaccine. I have been informed about the purpose of the COVID-19 vaccine, potential risks and benefits, and associated costs. I have been provided the chance to ask questions before going forward with a COVID-19 vaccine.

Parent/Legal Guardian/Individual Signature: ____ Date: __________________
Time: __________________

Print Name of Parent/Legal Guardian/Individual:_________________________________ Cell Phone Number: __________________

Date of Birth: ____________________

Address:____

City:____________________________ Zip Code:_________________________

For Administrative Use:

Manufacturer	Pfizer
Lot # Dose 1:_____________	Exp Date Dose 1:___/___/____
Date of Administration Dose1 ____/____/____	Site of Administration Dose 1 Left Arm / Right Arm
Lot # Dose 2:_____________	Exp Date Dose 2: ___/___/___
Date of Administration Dose 2 ____/____/____	Site of Administration Dose 2 Left Arm / Right Arm