

# COVID Vaccine Consent Form

## 2023–2024



### Section 1: Information About Child to Receive Vaccine (Please Print)

STUDENT'S NAME: (Last)	(First)	(M.I.)	STUDENT'S DATE OF BIRTH: Month:                      Day:                      Year:
PARENT/LEGAL GUARDIAN'S NAME:			
PARENT/LEGAL GUARDIAN DAYTIME PHONE NUMBER:			
Insurance Name & ID # :			

### Section 2: Screening for Vaccine Eligibility

The following questions will help us determine if there is any reason your student should not get the COVID-19 vaccine. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated—it just means we may contact you with additional questions.

	YES	NO
1. Has your student ever received <b>a dose of COVID-19 vaccine</b> ? If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your student received <b>a complete COVID-19 vaccine series</b> (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])?	<input type="checkbox"/>	<input type="checkbox"/>
3. Will your student bring their vaccination record card or other documentation?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your student ever had an allergic reaction to any of the following: (Note: This includes 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.) <input type="checkbox"/> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> <li>• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, OR</li> <li>• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.</li> </ul> <input type="checkbox"/> A previous dose of COVID-19 vaccine.	<input type="checkbox"/>	<input type="checkbox"/>
5. Has your student ever had an allergic reaction to <b>another vaccine</b> (other than COVID-19 vaccine) or an injectable medication? (Note: 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.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Check all that apply to your student: <ul style="list-style-type: none"> <li><input type="checkbox"/> Is a female between ages 18 and 49 years old</li> <li><input type="checkbox"/> Is a male between ages 12 and 29 years old</li> <li><input type="checkbox"/> Has a history of myocarditis or pericarditis</li> <li><input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies</li> <li><input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum</li> <li><input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection</li> <li><input type="checkbox"/> Has a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies</li> <li><input type="checkbox"/> Has a bleeding disorder</li> <li><input type="checkbox"/> Takes a blood thinner</li> <li><input type="checkbox"/> Has a history of heparin-induced thrombocytopenia (HIT)</li> <li><input type="checkbox"/> Is currently pregnant or breastfeeding</li> <li><input type="checkbox"/> Has received dermal fillers</li> <li><input type="checkbox"/> Has a history of Guillain-Barré Syndrome (GBS)</li> </ul>		

### Section 3: Consent for Child's Vaccination

I have read or had explained to me the 2023–2024 **COVID Vaccine Information Statement** and understand the risks and benefits.

**I GIVE CONSENT to School-Based Health Center and its staff for my child named at the top of this form to be vaccinated with this vaccine.**

SIGNATURE OF PARENT/LEGAL GUARDIAN: \_\_\_\_\_ Date: \_\_\_\_\_

☐ Please check box if you would like to come in with your child when vaccine is given. If box is not checked, vaccine will be given during school hours.