Covid-19 Vaccination Screening and Consent Form

School District: _____

Name: _____ **Date of Birth:** _____**Age:**_____
First and Last Name of Student Month/Date/Year

Address: _____ **City:** _____ **Zip:** _____

Parent/Guardian Name: _____ **Emergency Phone #:**_____

Student's Gender: ☐ Male ☐ Female

Student's Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Multi-racial or other ☐ Decline to answer

For Parent/Legal Guardian: *Please answer the following screening questions -*

1) I hereby certify that I have read the Pfizer Fact Sheet for Emergency Use Authorization (file attached to email). I understand the benefits as well as the usual and most frequent risks of receiving this vaccine.

   Parent/Legal Guardian Initial: _____

2) Please indicate the student's age range:
   ☐Under age 5 ☐5 to 11 ☐ 12 to 15 ☐ 16 to 49 ☐ 50 to 64 ☐ 65 and older

3) Has the student ever had a life-threatening allergic reaction to any vaccine?
   ☐ Yes ☐ No

4) Does the student currently have an acute illness and/or high fever?
   ☐ Yes ☐ No

5) Does the student have any of the following chronic illnesses?
   Asthma, cancer, chronic liver disease, chronic lung disease, heart disease, diabetes, kidney dysfunction
   ☐ Yes ☐ No

6) Does the student have current or planned immunosuppression?
   HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent or prednisone = 15 mg/day for =1 month) or other immunosuppressive medication
   ☐ Yes ☐ No

7) Has the student received any other vaccinations in the past 30 days?
   ☐ Yes ☐ No

8) Is the student pregnant or breastfeeding at this time?
   ☐ Yes ☐ No ☐ Not Applicable

For Vaccine Clinic Staff: *Initial here after reviewing the Student Information and Screening Questions*. _____

I want the student to receive the Covid-19 vaccination. I hereby certify that I have carefully read this Covid-19 Vaccination Screening and Consent Form, or have had it read to me, that I understand it, and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information, may result in an adverse outcome and be grounds for termination from this school-based vaccine program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered. On behalf of the student, I hereby release and hold harmless Akron Children's Hospital and its employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine(s) to the above-named student. By signing below, I acknowledge that I understand and accept the terms of this consent and confirm that I have legal ability to consent for the Covid-19 vaccine.

Student Signature (if 18 years or older) Date	Signature of Parent/Guardian Date Print Name of Parent/Guardian

To be completed at the Clinic:

FIRST DOSE:

Patient Age	Vaccine Administered	Mfg.	Lot #	Exp. Date	Site
	Covid-19	**Pfizer**			L R Upper arm

Clinic Location: Akron Children's Hospital, School Health Services

NURSE SIGNATURE_____ **DATE:** _____

NURSE PRINT_____

SECOND DOSE:

Patient Age	Vaccine Administered	Mfg.	Lot #	Exp. Date	Site
	Covid-19	**Pfizer**			L R Upper arm

Clinic Location: Akron Children's Hospital, School Health Services

NURSE SIGNATURE_____ **DATE:** _____

NURSE PRINT_____