ALLEN COUNTY PUBLIC HEALTH
Allen County Combined Health District

COVID-19 Immunization Screening and Consent Form (Age 6 months - 5 years)

Clinic Name: _____ Date_____

Name (please print):		Date of Birth:		Sex: M F
Age today:	Ethnicity: ☐ Hispanic origin ☐ Non-Hispanic origin		Race: ☐ Black or African American ☐ White ☐ Native American or Alaskan ☐ Other/multiracial ☐ Decline	
Address:	City:	State:	Zip:	County:
Phone:	Email Address:			
Primary Care Physician:	Social Security Number			

Please check if this applies:			
☐	First Dose	☐	Third Dose
☐	Second Dose		

Screening Questionnaire		
Is the person receiving the Covid vaccine today:	**Yes**	**No**
1. Between the ages of 6 months and 4 years-of-age?	☐	☐
2. Feeling sick today?	☐	☐
3. Ever received a dose of COVID-19 vaccine? If yes, which vaccine product did they use?	☐	☐
4. Received a complete COVID-19 vaccine series?	☐	☐
5. Did you bring your COVID vaccination record card?	☐	☐
6. Ever had a severe allergic reaction (e.g., anaphylaxis) to: • something other than a component of COVID-19 vaccine • polyethylene glycol (PEG) • polysorbate • a previous dose of COVID-19 vaccine • a vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐
7. Ever had an allergic reaction to another vaccine or any injection in the past? (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.)	☐	☐
8. Ever had a history of myocarditis or pericarditis?	☐	☐

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9. Ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?	☐	☐
10. Have a weakened immune system (i.e., from HIV or cancer) or on immunosuppressive drugs?	☐	☐
11. Have a bleeding disorder or taking a blood thinner?	☐	☐
12. Have a history of or a risk factor for a blood clotting disorder?	☐	☐
13. Have a history of heparin-induced thrombocytopenia (HIT)?	☐	☐
14. Have a history of Guillain-Barre Syndrome (GBS)?	☐	☐

Emergency Use Authorization

The Pfizer-BioNTech COVID-19 vaccine is available under emergency use authorization (EUA), for individuals 6 months through 4 years of age, and the Moderna COVID-19 vaccine is available under EUA for individuals 6 months through 5 years of age. The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA- approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Parent or Guardian Signature: _____ Date: _____

Relationship to patient: _____

Consent for Vaccination and Administrative Billing

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I have been given an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I authorize payment be made directly to ACPH for medical services provided to me or my family members. I authorize the release of any medical or other information necessary to process this claim.

Parent or Guardian Signature: _____ Date: _____

Relationship to patient: _____

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Area below to be completed by the vaccinator

Vaccine Name	Administration			Dosage/Route/Site			Lot Number/ Expiration date		Fact Sheet/ EUA Fact Sheet Date
Pfizer/ BioNTech	□ 1st Dose	□ 2nd Dose	□ 3rd Dose	0.2ml	IM	LD RD LVL RVL			6/17/22
Moderna	□ 1st Dose	□ 2nd Dose		0.25ml	IM	LD RD LVL RVL			6/17/22

□ I have reviewed side effects with parent/guardian, as applicable
□ I confirm that the parent/guardian was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and the best of my ability.

Vaccinator Signature _____Date_____

Insurance Information:

Primary Insurance	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	ID # Group #:
Policy Holder's Phone #:	Policy Holder's Date of Birth:
Secondary Insurance (*)	
Name of Insurance:	Policy Holder's Name:
Relationship to Patient:	ID # Group #:
Policy Holder's Phone #:	Policy Holder's Date of Birth: