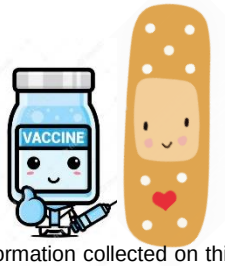
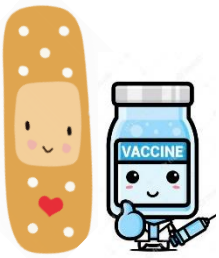


Wood County Health Department

COVID-19 Vaccine Administration Record and Screening for

5-11 YEAR OLD



Information collected on this form will be used to document authorization for receipt of vaccines. The information will be shared through the Wisconsin Immunization Registry (WIR) and Registry for Effectively Communicating Immunization Needs (RECIN) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and confidential. **Please Print.**

Child's Name: Last: | | | | | | | | | | | | | | | First: | | | | | | | | | | | | MI: |

Mother's Maiden Name:_____ **Printed name of person filling out consent**:_____

Age: ____ **Date of Birth:** month:_____ day:_____ year:_____ **Gender:** ☐ Male ☐ Female ☐ Other

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ Black/ African American ☐ American Indian ☐ Asian ☐ White ☐ Other Race

Questions for parents consenting their child receiving vaccine	**Yes**	**No**
1. Is your child sick today? (fever, cough, shortness of breath, nausea/vomiting in the last 24 hours)	☐	☐
2. Has your child received a previous COVID-19 vaccine? Date(s) _____ *Be prepared to show their card/documentation.*	☐	☐
3. Has your child ever had a **severe allergic reaction that required treatment with epinephrine/EpiPen or that caused you to go to the hospital, or that caused hives, swelling, wheezing, or respiratory distress to any of the following:** • A COVID-19 vaccine component (including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures)? • Polysorbate (which is found in some vaccines, film coated tablets, and IV steroids)? • A previous dose of COVID-19 vaccine, another vaccine, or injectable medication? List: _____ • Anything else (ex. other medication allergies, food, pets, venom, environmental allergies, etc.)? List: _____	☐	☐
4. Does your child have a history of heparin-induced thrombocytopenia (HIT)? (*If within 90 days of diagnosis, mRNA vaccine [Pfizer] is recommended. After 90 days, any COVID-19 vaccine may be offered.)*	☐	☐
5. Has your child been diagnosed with Multisystem Inflammatory Syndrome (MIS-C) after a COVID-19 infection? (*Consider delaying vaccination for 90 days after MIS; consult with health care provider*).	☐	☐
6. Has your child received antibody therapy/convalescent plasma for COVID in the past 90 days? (*if so, defer vaccination until 90 days has passed since treatment*).	☐	☐
7. Is your child currently in isolation or quarantine period due to COVID-19?	☐	☐

I have answered the above questions to the best of my knowledge and consent that my child be immunized. I have been given a copy and have read, or have had explained to me, information about the diseases and the vaccine to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of my child receiving a vaccine approved under an Emergency Use Authorization from the FDA. I understand that if my child has had a dermal filler, he/she may experience temporary swelling at or near the site of the filler injection (usually face/lips) and will contact my health care provider if swelling develops. I consent to having my child receive the vaccine in a public location. I have been made aware of the appropriate time my child is expected to be monitored for post-vaccination reactions based on risk factors. If my child is receiving a third dose of vaccine, I attest that he/she is doing so due to having a weakened immune system. **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to my child.**
Consent obtained/Signature and relationship to child:_____ **Date:** _____

Are you receiving: ☐ **Dose 1** ☐ **Dose 2** ☐ **Dose 3 (for immunocompromised; to be given at least 28 days after Dose 2)**

For Vaccinator/Office Use (Rev. 1/11/22)

Vaccine	Site	Trade name/Manufacturer Lot Number	Expiration Date	Dose
COVID-19	RD LD			0.2ml

Signature and Title – Person Administering Vaccine:_____ Date:_____

Entered into WIR/RECIN by:_____Date:_____