Children's COVID-19 Vaccine Consent Form

Please complete a questionnaire for each child receiving a COVID-19 vaccine

Name of person to receive vaccine (PRINT LEGIBLY BELOW):

Last:_____ First:_____ Middle Initial: _____

Address:_____
Number Street Apt.# City Zip code

Male☐ Female☐ Telephone #_____ Birthdate:_____ Age: _____

Please answer ALL questions (about the person receiving the vaccine)		
Is your child feeling sick today?	**YES**	**NO**
Has your child ever received a dose of COVID-19 vaccine?	**YES**	**NO**
Has your child ever had an allergic reaction to a COVID-19 vaccine or its ingredients? Has your child ever had an allergic reaction to laxatives?	**YES**	**NO**
Has your child ever had an allergic reaction to another vaccine?	**YES**	**NO**
Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to anything (Food, pet, medications, and/or environment)? Has your child been told to carry an EpiPen by a physician?	**YES**	**NO**
Has your child received any vaccine in the last 14 days?	**YES**	**NO**
Has your child ever had a positive test for COVID-19 or has a doctor ever told you that your child had COVID-19? Is your child currently on quarantine for COVID-19 exposure?	**YES**	**NO**
Has your child ever received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	**YES**	**NO**
Does your child have a weakened immune system caused by something such as HIV infection or cancer? Does your child take immunosuppressive drugs or therapies?	**YES**	**NO**
Does your child have a bleeding disorder or take blood thinners?	**YES**	**NO**
Is your child pregnant or breastfeeding?	**YES**	**NO**

Sign below if 18 or older. If person to receive vaccine is under 18, parent or legal guardian please sign below:

Consent for COVID-19 Vaccine: I have been given a copy and have read, or have had explained to me, the information contained in the *Emergency Use Authorization Fact Sheet*. I have had a chance to ask questions which were answered to my satisfaction. I have no further questions at this time. I believe I understand the benefits and risks of the COVID-19 vaccine. I request and voluntarily consent that the vaccine be given to me or to the person named for whom I am authorized to make this request. I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

I give my permission to the Amador County Public Health Department to enter and share my or my child's immunization record and any necessary identifying information in the immunization registry.

Signature:_____ Date: _____