

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?	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.

Guardian's full name: _____ Date: _____

Signature: _____ Date: _____