Gila River HEALTH CARE

Pediatric COVID-19 VACCINE CONSENT FORM 2020-2021

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Facility:

☐ HHK ☐ RTH ☐ KHC ☐ EMS ☐ TCH ☐ Dialysis East ☐ Dialysis West ☐ RTC ☐ Other: _____

Screening Questions	Yes	No	Don't Know
Is the child 16 years old or older?	☐	☐	☐
Has the child had a flu shot or any other vaccine in the past 14 days?	☐	☐	☐
Has the child been diagnosed with COVID-19 or under quarantine for COVID exposure in the past 14 days?	☐	☐	☐
Has the child received antibody or plasma treatment for COVID in past 90 days?	☐	☐	☐
Is the child feeling sick today? Does the child have a fever? Has the child taken any fever reducing medications in past 48 hours for fever?	☐	☐	☐
Does the child have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamycin, neomycin, phenol, yeast, polysorbate or polyethylene glycol)?	☐	☐	☐
Has the child ever had a severe allergic reaction called anaphylaxis (e.g., trouble breathing, broke out in hives, had facial or tongue swelling, had low blood pressure) to any food, medication, vaccine, insect stings, preservatives, cosmetics or any other injections? Does the child carry an epipen? Has the child been hospitalized for severe allergic reactions?	☐	☐	☐
Is the child immunocompromised or on medications that affect their immune system or lower immunity?	☐	☐	☐
Is the child pregnant, planning to become pregnant in the next 3 months or breast feeding?	☐	☐	☐
For those who have already received a COVID-19 vaccine. Manufacturer: _____ Date administered: _____	☐	☐	☐

Parent/Legal Guardian Consent

Please read and check all boxes below:

☐ FDA has authorized the emergency use of the COVID-19 Vaccine, which is not an FDA-approved vaccine.

☐ The parent/legal guardian has the option to accept or refuse COVID-19 Vaccine.

☐ Information about vaccine recipient will be shared with IHS and de- identified recipient information will be sent to CDC within 24 hours.

☐ I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine(s). I believe the benefits outweigh the risks and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s). I assume full responsibility for any reactions that may result.

☐ I authorize the release of the above medical information to the healthcare worker administering the vaccine.

☐ I consent and request that the COVID-19 vaccine my child receives today be entered into their patient chart at GRHC.

Parent/Legal guardian signature:_____ **Date:** _____

Patient/Guardian Print Name: _____ Date: _____

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