**COVID-19 VACCINE SCREENING AND CONSENT FORM**
**Ages 6 months – 14 Years**
**About the person getting injection (Please Print)**

**Patient Name:** _____ **Patient Age:** _____

| SCREENING QUESTIONS FOR PERSON RECEIVING INJECTION | | |
|---|---|---|
| The questions below will help us decide if the vaccine may be given during the clinic. | Circle Your Answer | |
| 1. Has your child had a positive COVID-19 test in the past 14 days? | YES | NO |
| 2. I have read and had questions answered about the EMERGENCY USER AUTHORIZATION (EUA) on the COVID-19 vaccine to be given to my child. | YES | NO |
| 3. I am aware that some people may experience physical responses to the injection, such as (but not limited to) injection site pain, light-headedness, or fainting. | YES | NO |
| 4. I understand the benefits and risks and request that the vaccine be given to the person named above for whom I am authorized to make this request. | YES | NO |
| 5. Has your child been feeling sick? If your child feels sick the day of the clinic, they should stay home. | YES | NO |
| 6. Which COVID-19 Vaccine Product will your child receive today? | PFIZER | MODERNA |
| 7. Has your child received a dose of COVID-19 vaccine? | YES | NO |
| a. If yes, which product? PFIZER MODERNA | OTHER | |
| 8. Has your child had a serious or life-threatening allergic reaction, such as anaphylaxis, hives, or difficulty breathing? If YES, does your child have an epi pen prescribed? YES / NO | YES | NO |
| 9. Does your child have any allergies? If YES, please list:_____ | YES | NO |
| 10. Have your child been diagnosed with multisystem inflammatory syndrome in children (MIS-C)? | YES | NO |
| 11. Is your child pregnant, or considering becoming pregnant? | YES | NO |
| 12. Does your child have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system? | YES | NO |
| 13. Does your child have any other medical or behavioral health issues that we should be aware of? Please describe: _____ | YES | NO |
| 14. Does your child take any medications that affect your immune system such as steroids, anticancer drugs, or have you had any radiation treatments? | YES | NO |
| 15. Which arm/thigh would your child prefer for the vaccine? | RIGHT | LEFT |

Samaritan Health Services

Samaritan Health Services
PO Box 3000
Corvallis, OR 97330

Last Name: First Name: Middle Initial:

Date of Birth:_____/_____/_____ Age:_____ Sex : ☐ Male ☐ Female
M D Y

Mailing Address: City: Zip:

Phone number: (_____) _____-_____ Email: _____

Insurance Provider*:_____

ID #:_____ Person Code (Suffix):_____ Group #:_____

Subscriber Name_____ Relationship to Patient:_____Subscriber DOB:_____

*Insurance is not required; this section can be left blank if not applicable.

Hispanic Ethnicity? ☐ Yes ☐ No ☐ Unknown Primary Language:_____
Race: ☐ American Indian/ Alaska Native ☐ Hispanic/Latino ☐ Native Hawaiian/ Pacific Islander
☐ Black/ African American ☐ White ☐ Asian ☐ Other: _____

I agree that I can review the Notice of Privacy Practices for Samaritan Health Services located at https://www.samhealth.org/patient-visitors/patient-privacy-rights.

**Consent for Minor's Vaccination:**
I have received, read, or had explained to me, and understand the COVID-19 vaccine information provided (information available at www.samhealth.org/getthevaccine). I hereby authorize Samaritan Health Services to administer the vaccine I have requested as a two-dose series. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed. In the event your child complains of symptoms consistent with an allergic reaction, they will be treated by onsite clinical personnel. This may include epinephrine injection and transport to the nearest emergency department if indicated.

Personnel will not restrain a child for purposes of vaccination. Children exhibiting severe anxiety or distress, refusal to proceed with injection, or any disruptive behavior will not be vaccinated.

I give consent for the child named at the top of this form to get vaccinated with Pfizer-BioNTech COVID-19 Vaccine. (If this consent form is not signed, dated, the child will not be vaccinated.)

Signature of Legally Authorized Representative: _____Date:_____

Relationship to Child:_____Phone number where you can be reached immediately if needed:_____

| THIS SECTION FOR CLINIC USE ONLY | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Dose #** | **EUA/VIS Given** | **Brand** | **Lot #** | **Exp. Date** | **Manuf.** | **Dose (mL)** | **Site/Rte** |
| | | | | | | | |
| | | | | | | | |

| | |
|---|---|
| **Date:** | **Vaccine Administrator Full Name/Title:** |
| **Time:** | **Vaccine Administrator Signature:** |