Consent and Administration Record-Monroe County Health Department-School Based COVID-19 Immunization Clinic

Health Department Address: 315 West Oak St, Sparta, WI, 54656

Information About Student Receiving Vaccine (s)-Please Print				
Name of Child's School	**Child's Grade**		**Classroom/Teacher**	
Student's Name (Last, First, Middle Initial)				
Date of Birth (mm/dd/yyyy)	**Age**	**Gender** ☐Male ☐Female ☐Self-Identify___________		
Mother's Maiden Name		**Telephone Number**		
Address		**City**	**State**	**Zip**
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino	**Race** ☐Asian ☐Black/African American ☐Native American/Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐Other Race ☐White			
Parent/Legal Guardian Name (Last, First):		**Phone Number (where you can be reached on date of clinic)**		

I understand the benefits and risk of the vaccine and ask that the vaccine be given to the child listed above for whom I am authorized to make this request

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety.

Questions for person receiving vaccine	**Yes**	**No**
1. Is the student currently in isolation or quarantine period due to COVID-19?	☐	☐
2. Has the student ever received a dose of COVID-19 vaccine?		
3. Has the student ever had a severe allergic (anaphylactic reaction)? If so, was it to a component of the COVID-19 vaccine, another vaccine, or an injectable (e.g., intramuscular, intravenous, or subcutaneous) therapy, food, or medication? **List:**__________________ *Please note, student will have to be observed for 30 minutes after receiving vaccine	☐	☐
4. Has the student received antibody therapy or convalescent plasma for COVID treatment in the past 90 days?	☐	☐
5. Have the student received another vaccine in the past 14 days?	☐	☐
6. Is the student pregnant or breastfeeding?	☐	☐

____

Signature of Parent/ Legal Guardian **Date Signed**

____

Printed Name of Parent/Legal Guardian **Relationship to Child**

Patient Name (Last, First)	Date of Birth (m/d/yyyy)

FOR OFFICE USE ONLY

Is person receiving ☐ Dose 1 or ☐ Dose 2

COVID-19 Vaccine Administered IM- Dose 0.5 ml
Manufacturer:
Lot #:
Expiration Date:

Site of Injection: ☐ Right Deltoid ☐ Left Deltoid ☐ Other_________________________

Signature of Vaccine Administrator: ______________________________ **Date:** __________
Time:_______

DATA ENTRY into Wisconsin Immunization Registry

Date: _______________ Initials: __________

Date EUA fact sheet for recipients and caregivers provided to parent/guardian ___________