Sierra County Public Health
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 enter and share my or my child's immunization record and any necessary identifying information in the immunization registry.

Signature:____ Date: ____________________

Sierra County Public Health
Pfizer-BioNTech COVID-19 Vaccine Consent
For Individuals Under 18 Years of Age

Section 1: Information about the child to receive Pfizer-BioNTech COVID-19 Vaccine (please print):

Child's Name (Last, First, Middle)	Date of Birth (mm/dd/yyyy)	Age	
Street Address	City	State	Zip
Phone Number			

Section 2: Information on the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine (Pfizer Vaccine).

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer Vaccine to prevent COVID-19 in individuals 12 years of age and older. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's Fact Sheet for Recipients and Caregivers.

Section 3: Consent.

I have reviewed the information on risks and benefits of the Pfizer Vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named above to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record web form.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Name (Last, First, Middle)	
Signature	Date
Address if different from above	
Phone Number if different from above	