CommunityCare Clinics
Minnesota

COVID-19 Vaccine Screening and Agreement FOR TWO DOSES.PFIZER-FDA EUA (5-11 YRS OLD). EUA (12-15). FDA APPROVED (16YRS AND ABOVE).

Contact information – person being vaccinated.

Last name: _____first name: _____Middle-IN ____

Age____ ***(THE CHILD HAS TO BE 5 YEARS AND ABOVE. 4 YRS PLUS A FEW MONTHS DO NOT QUALIFY)***

Date of Birth ___ /_____ /_____

Primary phone number: _____

Address (street or P.O. Box): _____

City: _____

State: _____

ZIP code: _____

Mother's name (last, first, middle - if younger than 18 years): _____

Mother's maiden name (if younger than 18 years): _____

Agreement

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the FDA approved (16 years and older) and EUA (5-11 AND 12-15 years) Fact Sheet for the following COVID-19 vaccine: [Pfizer-BioNTech vaccine].
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above.

Signature of patient or parent/guardian:

Date:___ /_____ /_____

_____Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it.

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Health history

If you answer yes to any of these questions, the person giving you the vaccine may need more information from you before you get the vaccine:

Yes	No	Unknown	Question
Yes	No		Are you the correct age to receive the COVID-19 vaccine? • **Pfizer-BioNTech** vaccine: **You must be 5 years or older.**
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients (including polyethylene glycol [PEG] or polysorbate or tromethamine for 5–11-year old's)?
Yes	No	Unknown	Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots.
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	Exposed to another person with known COVID-19 disease?
Yes	No	Not applicable	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product and date received:
Yes	No	Not applicable	Did you have a delayed allergic reaction at the injection site (e.g., redness, itching) after a first dose of COVID-19 vaccine?
Yes	No	Unknown	Have you received any other vaccines (that were not COVID-19 vaccine) within the past 14 days?
Yes	No	Not applicable	Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medication, foods, vaccinations, or latex?

DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation[1]	Fact Sheet Date	Route [2]	Manufacturer [3]	Lot Number	Admin Site[4]	Person Admin[5]
COVID-19 (Pfizer)		IM	PFR		Left deltoid/Right deltoid	

1. **COVID-19 Vaccine Presentation** = lists specific product name (e.g., Pfizer BioNTech.)
2. **Route:** IM = Intramuscular
3. **Manufacturer:** PFR = Pfizer
4. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid
5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines.

Signature or clinic administering vaccine: Odam Medical Group (612-871-2312)

Date administered: ___/___/_____