Salem Health Hospitals and Clinics

COVID-19 VACCINE FOR AGES 5-11 CONDITIONS TREATMENT, CONSENT & SCREENING

Salem Health® Hospitals & Clinics

PATIENT INFORMATION (PLEASE PRINT)

Last Name	**First Name**	**Middle Name**
Race	**Ethnicity**	
Date of Birth	**Phone Number**	**Gender (circle one) M / F / X**

CONDITIONS FOR TREATMENT: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

CONSENT: I have received, read, or had explained to me, and understand risks and benefits of the Pfizer-BioNTech (Pfizer) COVID-19 Vaccine information sheet provided or available at https://www.fda.gov/media/144414/download. In providing my consent below, I agree that I have legal authority on behalf of the child/minor named above to receive the Pfizer COVID-19 vaccine. I understand I may not be required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent below, the child/minor will receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment. The scope of this consent includes the administration of the vaccine, discussion with the provider, if requested, care and treatments immediately after administration as needed. I hereby authorize Salem Health, its staff or agents to administer the vaccine(s).

ASSIGNMENT OF INSURANCE BENEFITS: I assign to Salem Health the right to receive benefit payments directly from my health insurance or health plan for reimbursement for the administration of the COVID-19 vaccine. I understand that this assignment is final.

#	Screening Questions	Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you previously received a COVID-19 vaccine? If yes, when?	☐	☐	☐
2.	Have you been treated with antibody therapy for COVID-19 in the past 90 days?	☐	☐	☐
3.	Have been diagnosed with Multisystem Inflammatory Syndrome in Children (MIS-C) after a COVID-19 infection?	☐	☐	☐
4.	Have you had a serious or life threatening an allergic reaction such as hives or difficulty breathing to any vaccine or shot?	☐	☐	☐
5.	Have you had any vaccines in the past 14 days? (including flu shot)	☐	☐	☐
6.	Are you pregnant or breast-feeding?	☐	☐	☐
7.	Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system?	☐	☐	☐
8.	Do you take any medication that affect your immune system such as steroids, anticancer drugs or have you had any radiation treatments?	☐	☐	☐

Signature of Patient or Authorized Representative: _____ **Date:** _____

Print Patient Name: _____

----------**FOR DOWNTIME USE ONLY** **SITE LOCATION USE ONLY**----------

MRN: ___ _____ **CSN:** _____

DOSE #	Site (Circle One)	Route	Manufacturer (Circle One)	Lot #	Vaccine Exp. Date	Administered By & Date/Time (Print Name)	
☐ 1 ☐ 2	LD RD	IM	Pfizer Pediatric			DATE & TIME OF ADMINISTRATION	11-9-21 v.16