CONEJO CHILDREN'S MEDICAL GROUP
COVID-19 VACCINE SCREENING AND CONSENT FORM

Name____Date of Birth__________________________

COVID-19 SCREENING QUESTIONS	YES	NO
1. In the past 2 weeks have you tested positive for COVID-19?	☐	☐
2. In the past 10 days have you had fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, or runny nose, nausea, vomiting or diarrhea?	☐	☐
3. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine including polyethylene glycol?	☐	☐
4. Have you had a severe allergic reaction to any medications, foods, vaccines or latex?	☐	☐
5. Do you carry an Epi-pen for emergency treatment of anaphylaxis?	☐	☐
6. Are you immunocompromised or on a medicine that affects your immune system?	☐	☐
7. Do you have a bleeding disorder or are you on a blood thinner/blood thinning medication?	☐	☐
8. Have you been treated with antibody therapy or convalescent plasma for COVID-19 In the past 90 days (3 months)? If yes, date of last dose_________________	☐	☐
9. Have you received a previous dose of any COVID-19 vaccine? If yes, which vaccine did you receive?_________________________Date_______________	☐	☐

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 6 months of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Conejo Children's Medical Group to administer the COVID-19 vaccine.

I understand that this product has approved and licensed by the FDA for ages 16 and up and has been authorized for emergency use by the FDA, under an EUA to prevent COVID-19 for use in individuals 6 mo. to 15 years of age.

I understand that it is not possible to predict all the possible side effects or complications associated with receiving vaccines. I understand the risk and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and such questions were answered to my satisfaction.

I acknowledge and agree to remain at the vaccination location for approximately 15 minutes after administration for observation in case any immediate reactions occur. On behalf of myself, my heirs and personal representatives, I hereby release the providers administering the vaccine (Conejo Children's Medical Group) and their owners, administrators, employees and agents from any and all liabilities or claims whether known or unknown arising out of, in connection with, or any way related to the administration of the vaccine listed above.

Signature of Patient/Authorized Representative____

For Minors, Print Name and Relationship____Date________________

OFFICE USE: ☐ Pfizer 6 mo-4 yr ☐ Pfizer 5-11 yr ☐ Pfizer 12yr + ☐ MODERNA 6mo-5 yr ☐ MODERNA 18+

Initials_______________