Covid-19 Immunization Screening and Consent Form

For Children Ages 5 to 11 Years Old

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TheGatewayPharmacy.com

Vaccine Recipient Information			
Recipient Name:	**Last:**	**First:**	**M.I.:**
Date of Birth:		**Preferred Language:**	
Gender		**Phone Number:**	
Parent/Guardian/Surrogate Name: *(if applicable, please print)*		**Email Address:**	
Street Address:			**Apartment/Unit:**
City:		**State:**	**Zip Code:**

Please Answer the Following Questions by Circling Your Response	
Ethnicity:	Non-Hispanic Origin Hispanic Origin Unknown Declined
Race:	Asian African American or Black White Other or Multiracial
	Native American or Alaskan Native Hawaiian or Pacific Islander Declined

Screening Questionnaire				
1.	Is your child feeling sick today?	☐ Yes	☐ No	☐ Unknown
2.	In the last 10 days, has your child had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes	☐ No	☐ Unknown
3.	Has your child had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	☐ Yes	☐ No	☐ Unknown
4.	Does your child carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?	☐ Yes	☐ No	☐ Unknown
5.	Has your child had any allergic reaction after a COVID-19 vaccine?	☐ Yes	☐ No	☐ Unknown
6.	Has your child had any allergic reaction after receiving another vaccine or injectable medication?	☐ Yes	☐ No	☐ Unknown
7.	Has your child had any allergic reaction after receiving polyethylene glycol or polysorbate?	☐ Yes	☐ No	☐ Unknown
8.	Is your child immunocompromised or on medications that affect immunity?	☐ Yes	☐ No	☐ Unknown
9.	Does your child have a bleeding disorder or on a blood thinner?	☐ Yes	☐ No	☐ Unknown
10.	Does your child have a history of Guillain-Burre Syndrome OR multisystem inflammatory syndrome (MIS-C or MIS-A)?	☐ Yes	☐ No	☐ Unknown
11.	Does your child have a history of an immune-mediated syndrome characterized by thrombosis (abnormal blood clots) and thrombocytopenia (low platelets), such as heparin-induced thrombocytopenia (HIT)?	☐ Yes	☐ No	☐ Unknown

Emergency Use Authorization

The U.S. Federal Drug Administration (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 cleared product. 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 generally outweigh the known and potential risks.

Authorization and Consent

CONSENT AND RELEASE: I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am guardian was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am guardian). I hereby release and forever discharge and hold harmless the Gateway Pharmacy, its officers, employees, agents, and/or assigns (hereinafter: Releasees), from any and all liability, claims, demands, and/or causes of action, either in law or equity, which may hereafter arise from my receipt of the COVID-19 vaccine with respect to any bodily injury (including but not limited to potential allergic reactions and infections) or other injury, including any mental injury, illness, death, or property damage that may result. I understand that the Releasees do not assume any responsibility or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance in the event of injury, illness, death or property damage, unless otherwise expressly governed by and interpreted in accordance the laws of the Commonwealth of Pennsylvania. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

CONSENT AND HIPAA PRIVACY INFORMATION: I have read the above Consent and Release and understand its provisions. I understand that participation in this COVID-19 vaccination program is completely voluntary and not required. I understand the risks and benefits of the vaccine and I request that the vaccine be given to me or the person named above for whom I am the legal guardian. I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I hereby freely and voluntarily, without duress, execute this Consent and Release under the above written terms.

Signature: *Recipient/Surrogate/Guardian*		**Date:**

Print Name:		**Relationship to Patient:** *If other than recipient*	

DO NOT Complete This Section. To Be Completed By Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	*Administration*			*EUA Fact Sheet Date*	Manufacturer & Lot Number
Pfizer/BioNTech	☐ First Dose	☐ Second Dose			

Admin Site:	☐ Left Deltoid	☐ Right Deltoid	☐ Left Thigh	☐ Right Thigh
Dosage:	☐ 0.2 mL			

	I hereby attest by my signature that the patient (or guardian of patient) in question has been provided access to and explained the Vaccine Information Statement and appropriate immunization schedules and has given verbal and written consent for vaccination.
	I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)
	I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Administration Signature:		**Date:**