Center City Pediatrics

COVID VACCINE CONSENT AND QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ Patient Date of Birth: _____

Does the patient have a fever over 100.0F or feeling ill today? • If yes, reschedule appointment to administer vaccine when fever free	YES / NO
Has the patient ever received a dose of the COVID-19 vaccine? • If yes, what was the manufacturers name: _____ • Date of COVID-19 vaccine: _____ (ensure proper interval from vaccine date)	YES / NO
Has the patient had history of severe allergic reaction (ex: anaphylaxis) to an injectable therapy? • If yes, schedule an appointment with your provider	YES / NO
Has the patient had history of severe allergic reaction (ex: anaphylaxis) to another vaccine? • If yes, schedule an appointment with your provider	YES / NO
Has the patient had history of other serious reaction (ex: anaphylaxis) due to any cause? • If yes, requires a 30-minute observation in the office	YES / NO
Has the patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? • If yes, do NOT vaccine for 90 days from the last treatment date	YES / NO
Does the patient have a weakened immune system caused by something such as HIV infection or cancer OR does the patient take immunosuppressive drugs or therapies? • If yes, schedule an appointment with your provider	YES / NO

I have received the Emergency Use Authorization document from the CDC and have read, or have had explained to me, information about the vaccine. I had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request.

Parent/Guardian Signature: _____

PRINT Parent Guardian Name: _____

Relationship to Child: _____

Back Office Use Only: Center City / Bala / Fishtown

MA Initials: _____ Lot #: _____ Site of Injection: _____

Exp Date: _____ Mfr: Pfizer