COVID VACCINE PARENTAL CONSENT FORM

This form must be signed, dated, and returned with other vaccine paperwork.

I _____ authorize my child, _____

To receive a Pfizer Covid 19 vaccine. I acknowledge my child is **16 years or older**. I acknowledge this is a two part vaccination with the second vaccine to be given at least 21 days after the first vaccine.

A copy of your child's medical insurance card and pharmacy prescription card must be attached to returning forms.

Any questions or concerns, please call Hy-Vee Pharmacy at 712-542-6546.

Child's full legal name _____

Child's date of birth _____

Parent/legal guardian's **printed name**

_____

Parent/legal guardian's **signature**

_____

Parent/legal guardian's phone number if need to be reached regarding vaccine consent or insurance information.

_____

Hy-Vee Informed Consent to Receive Vaccines

Manufacturer: **Pfizer-BioNTech** Dose Number:
Name: Date of Birth: Gender: Ethnicity:
Street: City: **Clarinda** Zip: Race:
Phone: Primary Care Provider:

1. Are you sick today?	☐ Yes ☐ No ☐ Don't Know
2. Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. If Yes, the vaccine is contraindicated)	☐ Yes ☐ No ☐ Don't Know
3. Have you ever had an allergic reaction to Polysorbate? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. If Yes, the vaccine is contraindicated)	☐ Yes ☐ No ☐ Don't Know
4. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. If Yes, the vaccine is contraindicated)	☐ Yes ☐ No ☐ Don't Know
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? (This would include food, pet, environmental, or oral medication allergies. Yes = Provider to observe patient for 30 min)	☐ Yes ☐ No ☐ Don't Know
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing. Yes= Provider observe pt for 30 min)	☐ Yes ☐ No ☐ Don't Know
7. Do you have a weakened immune system caused by something such as cancer or HIV infection or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No ☐ Don't Know
8. Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No ☐ Don't Know
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐ Yes ☐ No ☐ Don't Know
10. Have you received any vaccine in the last 14 days?	☐ Yes ☐ No ☐ Don't Know
11. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ Yes ☐ No ☐ Don't Know
12. In the past 14 days, have you tested positive for COVID-19 or are you currently waiting on the results of a COVID-19 test?	☐ Yes ☐ No ☐ Don't Know
13. Within the past 14 days, have you been in close physical contact with anyone who is known to have laboratory-confirmed COVID-19?	☐ Yes ☐ No ☐ Don't Know
14. Within the past 14 days, have you been in close physical contact with anyone who has any symptoms consistent with COVID-19?	☐ Yes ☐ No ☐ Don't Know
15. Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea?	☐ Yes ☐ No ☐ Don't Know
16. Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	☐ Yes ☐ No ☐ Don't Know
17. Have you ever received a dose of a COVID-19 vaccine?	☐ Yes ☐ No ☐ Don't Know
18. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No ☐ Don't Know

PAYMENT AUTHORIZATION. I hereby authorize Hy-Vee Pharmacy to request payment and release all information needed to act on this request. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS. I acknowledge that Hy-Vee Pharmacy may be required to or may voluntarily disclose my health information concerning the vaccine(s) to my primary care physician (if provided), my insurance plan, and/or local, state, or federal registries/health agencies, if applicable. I acknowledge that, depending on my state law, I may object to the disclosure of my vaccination information to the state registry. I understand that my health information will be used and disclosed as set forth in the Hy-Vee Pharmacy Notice of Privacy Practices, which is available online or upon request.

CONSENT FOR VACCINE SERVICES. I have read, or have had read to me, the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) provided for the vaccine(s) to be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and voluntarily assume full responsibility for any reactions that may result. I give my consent to the staff of Hy-Vee Pharmacy to administer the vaccine(s) marked above. I have been advised to stay in the general area for 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release Hy-Vee, its officers, employees and agents from any and all liability, whether known or unknown, that in any way arise from this vaccination on behalf of myself, my heirs and personal representatives.

By signing below, I certify that I am the patient or the patient's guardian/personal representative signing on behalf of the patient, and that I have read, understood, and agreed to all the statements above.

Patient or Guardian Signature _____ Date _____

Administered Pharmacist	Admin Date	Vaccine	Vaccine Lot #	Exp Date	Manufacturer	VIS Date	Dose (mL)

Admin Site: Right---Left - Arm---Thigh—Nasal -- SQ -- IM Adverse Reaction (attach VAERS form) Notification to Primary Provider _____ (date)