BRUNSWICK COUNTY HEALTH SERVICES
PFIZER COVID-19 VACCINE CONSENT FORM

Child's Full Name: _____**Date of Birth** ____/_____/_____
Parent/Legal Guardian Name (please print): _____
Parent Email Address: _____ ☐ No email
Best phone number to reach you at if we need to call you during your child's visit:
Home Phone Number: _____**Mobile Phone Number:** _____
Address: _____ **City:** _____
Zip Code: _____ **County:** _____**State:** _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify
Preferred Language: ☐ English ☐ Vietnamese ☐ Arabic ☐ French
☐ Spanish ☐ Hindi ☐ Other ☐ Decline to state
Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric)
☐ Neurological ☐ Physical (Mobility) ☐ Respiratory
☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _____)

Individual bringing your child(ren) to the appointment (please print): _____
Relationship to child(ren): _____

Initial and sign below to give consent for Brunswick County Health Services to vaccinate your child.

_____I CERTIFY THAT I AM: the parent/legal guardian of the patient. Further, I hereby give my consent to Brunswick County Health Services to administer the Covid-19 vaccine and share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

THE VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE INSURANCE OR NOT.
I understand my signature serves as legal "signature on file" for purposes of consent, filing insurance/Medicaid claims and payment of benefits to BCHS for vaccine administration services rendered.

_____ _____
Parent/Legal Guardian Signature **Date**

PREVACCINATION CHECKLIST FOR COVID-19 VACCINES	Yes	No	Don't Know
1. Is your child feeling sick today			
2. Has your child ever had an allergic reaction to: *(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.)*			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), found in some medications, such as laxatives and preparations for colonoscopy procedure			
• Polysorbate, found in some vaccines, film coated tablets, and intravenous steroids			
3. Has your child 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]*			

4. Check all that apply to your child:
□ Have a history of myocarditis or pericarditis
□ Had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable therapy such as food, animals, venom, environmental, or oral medications?
□ Had Covid-19 and was treated with monoclonal antibodies or convalescent serum
□ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid -19 infection
□ Have a weakened immune system or take immunosuppressive drugs or therapies
□ Have a bleeding disorder
□ Take a blood thinner
□ Have a history of heparin-induced thrombocytopenia (HIT)
□ History of Guillain-Barré Syndrome (GBS)