BRUNSWICK COUNTY HEALTH SERVICES
COVID-19 VACCINE CONSENT FORM

FRONT AND BACK PAGES MUST BE COMPLETED

Child's Full Name: ____

Date of Birth ____/_____/______ **Child's Age:** ______________

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): ____

Please check the Covid vaccine you want Brunswick County Health Services to give your child:

☐ Pfizer primary series/booster (age-appropriate version)

☐ Moderna booster (age-appropriate version)

Print your name 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
(Print Name)
my consent to Brunswick County Health Services to administer the Covid-19 vaccine checked above 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 **RECIPIENT AGE:**	**Yes**	**No**	**Don't know**
1. Is your child feeling sick today?			
2. Has your child ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you receive? □ Pfizer □ Moderna □ Other: • How many doses has your child received?			
3. Does your child have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematocrit therapy [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*			
4. Has your child received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?			
5. 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			
• A previous dose of COVID-19 vaccine			
6. 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]*			

7. Check all that apply to your child:

□ Had a severe allergic reaction (e.g., anaphylaxis) to anything (food, animals, venom, environmental, or medications)?

□ History of myocarditis or pericarditis

□ History of multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a Covid -19 infection

□ History of an immune-mediated syndrome with thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT), OR history of thrombosis with thrombocytopenia syndrome (TTS)

□ History of Guillain-Barré Syndrome (GBS)

□ History of prior Covid-19 disease or (+) test Date: __________________