COVID-19 VACCINE ADMINISTRATION RECORD (VAR)
About the child receiving injection (Please Print)

Patient Name: _____ **Patient Age:** _____

SCREENING QUESTIONS FOR PERSON RECEIVING INJECTION		
The questions below will help us decide if the vaccine may be given today. If you need help with these questions, please ask the clinic staff to help you.	Check (☑) Yes or No	
	YES	**NO**
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine?		
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson (Janssen) ☐ Other: _____		
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		
• Was the severe allergic reaction after receiving a COVID-19 vaccine?		
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
5. Have you been diagnosed with multisystem inflammatory syndrome in children (MIS-C)?		
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
8. Are you pregnant or breastfeeding?		

Linn County Public Health
315 SW 4th Ave
Albany, OR 97321
(541) 967-3888

Patient Last: First: Middle:

Date of Birth:_____/_____/_____ **Age**:_____ Sex : ☐ Male ☐ Female
M D Y

Mailing Address: City: Zip:

Phone number: (_____) _____-_____ Email: _____

Hispanic Ethnicity? ☐ Yes ☐ No ☐ Unknown Primary Language:_____
Race: ☐ American Indian/ Alaska Native ☐ Hispanic/Latino ☐ Native Hawaiian/ Pacific Islander
☐ Black/ African American ☐ White ☐ Asian ☐ Other: _____

Parent or Guardian Consent for Minor Vaccination

I have reviewed the information on risks and benefits of the Pfizer COVID-19 Vaccine above and understand the risk and benefits. In proving my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the Emergency Use Authorization (EUA) on the COVID-19 Vaccine includes more detailed information about the potential risks and benefits of the Pfizer COVID-19 Vaccination.
2. I have the legal authority to consent on behalf of the child/minor named above to vaccination with the Pfizer COVID-19 Vaccine.
3. I understand I may not be required to accompany the child/minor named above to their vaccination appointment and that, by giving my consent below, the child/minor will receive the Pfizer COVID-19 Vaccine whether or not I am present at the vaccination appointment.
4. I agree that I can review the Notice of Privacy Practices for Linn County Health Department located at https://www.linncountyhealth.org/ha/page/compliance-privacy-office.

I GIVE CONSENT for the child/minor named at the top of this form to get vaccinated with the two-dose Pfizer COVID-19 Vaccine and I have reviewed and agree to the information included in this form. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed (If this consent is **NOT** signed, dated and returned, the child/minor will not be vaccinated.)

Relationship to Minor **Printed Name**

Signature of Parent/Guardian **Date**

THIS SECTION FOR CLINIC USE ONLY

Dose #	EUA Given	Brand	Lot #	Exp. Date	Manuf.	Dose (ML)	Site/Rte
					Pfizer **(Pediatric)**	0.2	RD LD

Date:	**Vaccine Administrator Full Name/Credentials:**
Time:	**Vaccine Administrator Signature:**