PEDIATRIC COVID
Vaccine Screening, Patient Consent, & Administration Record

Name:____ **SSN:**_______________

Birthdate:_______________ **Age:** ________ **Phone:** ________________ **Gender (circle one): Male / Female**

Address:____

City, State, Zip:_________________________ **Primary Care Physician:** _______________________

Race: (Circle One): American Indian/Alaska Native - Asian - Black/African-American - Native Hawaiian/Pacific Islander - White - Other

Ethnicity (Circle One): Hispanic/Latino - **Not** Hispanic/Latino

Parent Email:____

Screening Questions:	Yes	No
Do you consent to this vaccination being recorded in the Texas Immunization Registry (ImmTrac2)?		
Have you had a positive covid test? If yes, what date was the test positive: _____________		
Have you had a covid-19 vaccine? If yes, what date was the 1st dose: _____________		
Have you experienced a severe reaction to any vaccine (anaphylaxis)?		
Have you been diagnosed with Multi System Inflammatory Disease (MIS)?		

Patient/Parent Consent: I have read, or have had read to me, the EUA regarding the vaccine I am about to receive. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to, or give consent for, the administration of the vaccine and the notification of my primary care physician. I authorize the release of any medical or other information necessary to process this claim. I understand that I should remain in the pharmacy for 15 minutes for observation in case there is an adverse reaction.

Parent Signature: ____**Date:** ___________________

FOR OFFICE USE ONLY:

Date	Vaccine	Manufacturer	Dose	Lot	Exp Date	Site	Amt/Admin	EUA Date	Administrator
	Pediatric Covid-19 Vaccine	Pfizer	1st	FL8094	03/14/22	RA/LA	0.2 mL IM	2021	
	Pediatric Covid-19 Vaccine	Pfizer	2nd	FL8094	03/14/22	RA/LA	0.2 mL IM	2021	

Updated 1/10/2022