Public Health
Prevent. Promote. Protect.
Rock Island County Health Department

SchoolHealthLink

COVID-19 Pediatric Vaccine Consent form

Name (Last, First, MI)	**DOB:** / /
Address	**Age:**
City/State/ZIP	
Phone	

Your primary care doctor/provider's name, city, state: _____

Required by the State of Illinois:

Race: Hispanic/Latino □ Not Hispanic/Latino □ Unknown □

Ethnicity: American Indian/Alaska Native □ Asian □ Black/African American □ Hispanic/Latino □ Native Hawaiian/Pacific Islander □ Other Race □ Unknown □ White □

	YES	NO
Have you ever had a serious reaction to a vaccine or other injectable drug, if yes, which medication and what was the reaction? Allergy to Polysorbate or PEG, if yes, what was the reaction?	□	□
Do you have any other serious allergies? Please list:	□	□
Have you received a previous single dose or 2-dose series of a COVID-19 vaccine? If yes, number of doses and brand of vaccine:	□	□
Are you able and willing to remain onsite for 15-30 minutes after your vaccine?	□	□

□ **I have read or had explained to me the COVID-19 Vaccine EUA Fact sheet and understand the risks and benefits. I GIVE CONSENT to the Rock Island County Health Department authorized employee or designee to administer the COVID-19 Vaccination.**

Signature: _____ Date: _____
Vaccine recipient (or Parent/Guardian, if applicable)

Vaccination Record (FOR ADMINISTRATIVE USE ONLY)

EUA provided: Y / N Vaccination Card provided: Y / N If vaccine deferred, please state reason:

Temperature:

Vaccine: COVID-19	Route: IM Deltoid	Date Administered	Manufacturer	Lot Number	Name & Title of person administering vaccine
Dose #1 Pfizer Child	L R		Pfizer		
Dose #2 Pfizer Child	L R		Pfizer		