

# Consent to Administer COVID- 19 vaccine

**Provider will offer a 2-dose COVID-19 vaccine to students ages 16+**

**FILL OUT THIS FORM ONLY IF YOU WILL ALLOW YOUR CHILD TO GET A 1<sup>st</sup>  
and 2nd DOSE of COVID-19 VACCINE**

<b>SCHOOL NAME:</b>				<b>Grade/HR</b>	
<b>PLEASE PRINT PATIENT INFORMATION</b>					
<b>STUDENT NAME</b> (Last Name):		(First Name):		(M.I.):	
<b>MRN/Control#</b>					
Date of Birth:		Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other		Ethnic Group <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic	
Parent/Guardian (If different than patient):					
Race: <input checked="" type="radio"/> Alaskan Native <input type="radio"/> AM-American Indian <input type="radio"/> Asian <input type="radio"/> Black/African American <input type="radio"/> Native Hawaiian <input type="radio"/> Prefer Not to Disclose <input type="radio"/> Unknown <input type="radio"/> White					
Street Address: Apt. #:		City:		State:	County:
Zip Code:	Home Phone:	Alternate/Cell Phone:		Email Address:	
<b>EMERGENCY CONTACT:</b>					
Name: _____ Relationship: _____ Phone Number: _____					
Are we able to leave messages with your emergency contact Yes _____ No _____					
<b>PRESCREENING QUESTIONS:</b>					
1. Has the child tested positive for COVID-19 in the past 10 days? <input type="radio"/> Yes or <input type="radio"/> No					
2. Does the child have any of the following new or worsening symptoms: cough, vomiting, diarrhea, fever, new loss of sense of smell, new loss of sense of taste, sore throat, or runny nose? <input type="radio"/> Yes or <input type="radio"/> No					
3. Is the child currently under quarantine by the health department (includes notices by school/daycare/workplace) for COVID-19 exposure? <input type="radio"/> Yes or <input type="radio"/> No					
4. Has the child received antibody or plasma treatment given by a needle into the vein for COVID-19 in the past 90 days? <input type="radio"/> Yes or <input type="radio"/> No					
5. Has the child had a severe allergic reaction from a vaccine or after a medicine was given by a needle or in the vein that caused trouble breathing, the use of an Epi-Pen, or emergency medical treatment? <input type="radio"/> Yes or <input type="radio"/> No					
6. Has the child received any vaccine in the past 14 days? <input type="radio"/> Yes or <input type="radio"/> No					

7. Has the child received the first dose of the COVID vaccine?  Yes or  No. If yes when and where?

Where: \_\_\_\_\_ When: \_\_\_\_\_

If you answered "Yes" answers to questions 1, 2, 3,4, or 6 the child will not be able to get the COVID vaccine at this time. Please contact your Primary Care Provider to determine when your child can get it.

If you answered "Yes" to question 5 please schedule your vaccine with your Primary Care Provider or by visiting [gettheshot.coronavirus.ohio.gov](http://gettheshot.coronavirus.ohio.gov).

**Authorization and Consent for Covid-19 Vaccine:**

The Food and Drug Administration has authorized the emergency use of the COVID-19 vaccine to prevent COVID-19. I have had a chance to ask questions about the vaccine.

I voluntarily consent and allow this provider to give the 2 dose COVID Vaccine. The second dose must be given 21 days after the first dose is received. Your child will get their second dose at the same place they got their first dose..

I understand I will be offered the Manufacturer Vaccine information sheet after my child gets the vaccine. Any questions I have about the COVID-19 vaccine can be answered by the provider or by visiting <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>.

**Disclosure to Government Authorities:** I acknowledge that my child's vaccine record, and associated information may be shared with appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

**Release:** To the fullest extent permitted by law, I hereby release, discharge and hold harmless this provider, including, without limits, any of its officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my child's COVID-19 vaccine or the disclosure of my child's COVID-19 vaccine records.

I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form and consent to the COVID-19 vaccine. I have been informed about the purpose of the COVID-19 vaccine, potential risks and benefits, and associated costs. I have been provided the chance to ask questions before going forward with a COVID-19 vaccine.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Time: \_\_\_\_\_

Print Name of Parent/Legal Guardian: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_