Clark County Health Department 517 Court Street, Room 105 | Neillsville, WI 54456

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PFIZER PEDIATRIC (AGES 5-11) COVID-19 VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of the COVID-19 vaccine, and will be shared through the Wisconsin Immunization Registry (WIR). Information collected on this form is voluntary and confidential.

Please answer the following questions:	**Yes**	**No**
1. Is the child 5 to 11 years old?		
2. Is the child currently experiencing a moderate or severe acute illness with or without fever?		
3. Has the child been instructed by public health to isolate at this time due to COVID-19 infection?		
4. Has the child ever experienced a severe allergic reaction (hives, swelling, wheezing, or respiratory distress) requiring medical care or treatment with epinephrine (EpiPen) to: ▪ A previous dose of COVID-19 vaccine ▪ A component of a COVID-19 vaccine, including Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures) ▪ Polysorbate (which is found in some vaccines, film coated tablets, and IV steroids)		
5. Does the child have a past or current diagnosis with MIS-C (Multisystem Inflammatory Syndrome in Children)?		
6. Does the child have a past or current diagnosis with myocarditis or pericarditis?		
7. Is the child immunocompromised (have a weakened immune system)?		

Information about the child receiving the COVID-19 vaccine (please print):

Last Name: **First Name:** **M.I.** **Age:**

Date of Birth Month: Day: Year: **Sex:** Male ☐ Female ☐ Other ☐

Ethnicity: Hispanic ☐ Not Hispanic ☐ **Race:** White ☐ African American ☐ Asian ☐ Other ☐

Address: Street, City, Zip Code **Phone #** **County**

I have answered the above questions to the best of my knowledge. I have been offered a copy of the Pfizer Pediatric (ages 5-11) COVID-19 vaccine fact sheet. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of my child receiving a vaccine approved under an Emergency Use Authorization (EUA) from the FDA. I understand that if my child has had a dermal filler, he/she may experience temporary swelling at or near the site of the filler injection (usually face/lips) and will contact my child's healthcare provider if swelling develops.

I have been made aware of the appropriate time my child is expected to be monitored for post-vaccination reactions based on their risk factors. I understand children & adolescents are at increased risk of syncope (fainting), following any injectable vaccine. *If my child is receiving a third (additional) dose of the vaccine, I attest that he/she meets the eligibility criteria.* **I request the COVID-19 vaccine to be given to my child.**

By signing this form, I authorize the Clark County Health Department to release the necessary information to the insurance carrier indicated below, to process this claim. I understand I will not be held responsible to pay the COVID-19 vaccine administration fee, if my insurance carrier denies payment or if I have an insurance carrier that the CCHD does not accept.

Signature of Parent or Legal Guardian **Date:**

X _____

STOP - FOR CLINIC/OFFICE USE ONLY			
Vaccine ☐ PFIZER PEDIATRIC (5-11Y) COVID-19	**LOT:** **BUD:**	**Dose** ☐ 0.2 ML	**Injection Site** LD / RD LV / RV
Signature & Title of Vaccine Administrator:		**Date:**	
☐ WIR ☐ Billed			*Updated: 2.22.2022*
INSURANCE INFORMATION			
Primary Insurance Carrier Provider:			
Member ID / Subscriber or ID #:			
Secondary Insurance Carrier Provider (if applicable):			
Member ID / Subscriber or ID # for Secondary Insurance (if applicable):			