

Bechtel's Pharmacy
Screening Questions and Consent form for Child's Covid-19 Vaccine

Patient Name: _____

Address: _____

Phone #: _____

Place of Birth: _____ Race/ethnicity: _____

Date of Birth: _____ Today's Date: _____

Primary Care Dr: _____ Dr's Phone#: _____

Dr's Address: _____

Circle Yes or No for the following Questions:

Are you feeling sick today? Do you have a fever?	YES	NO
Have you received immunizations in the past?	YES	NO
Have you ever received a previous dose of COVID-19 vaccine? If so which vaccine?	YES	NO
Have you ever had an allergic reaction any component of the COVID-19 vaccine, including Polyethylene glycol (PEG)? Polysorbate? A previous dose of COVID-19?	YES	NO
Have you ever had an allergic reaction to another vaccine or an injectable medication?	YES	NO
Have you ever had a severe allergic reaction?	YES	NO
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
Do you have cancer, leukemia, AIDS or any other immune system problem? Do you take immunosuppressive drugs or therapies?	YES	NO
Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
Do you have a history of/risk factor for a blood clotting disorder?	YES	NO
Do you have dermal fillers?	YES	NO
Are you pregnant or breast feeding?	YES	NO
Have you received any vaccinations in the past 14 days?	YES	NO

I give consent to Bechtel's Pharmacy and its staff to administer this vaccine to my child named on the top of this form.

Parent's Signature: _____

Parent's Name (printed): _____ Date: _____

Vaccine Lot #: _____ Pharmacist's Initials: _____

Dose: _____ Manufacturer: _____ Expiration Date: _____
Site of Administration: _____ Date of VIS: _____