SAN BERNARDINO COUNTY | COVID-19 Response

COVID-19 VACCINE MINOR CONSENT FORM FOR INDIVIDUALS AGED 17 AND YOUNGER

Section 1 – Information of minor to receive COVID-19 Vaccine (please print):			
Minor's Last Name	*Minor's First Name*		*Minor's Middle Name*
Date of Birth (MM/DD/YYYY)	*Minor's Age*	*Minor's Weight (lbs):*	*Parent/Guardian Phone Number*
Street Address, City, State, Zip Code			*Parent/Guardian Email*
Mother's Maiden Name (Maiden Last Name, First Name)			

Gender: (Check one)	*Race: (Check one)*		
☐ Female ☐ Male	☐ American Indian	☐ Alaska Native	☐ Asian
☐ Nonbinary	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Black or African American
☐ Decline to Answer	☐ White	☐Other _____	☐ Decline to Answer

Section 2 – Screening Questions	**YES**	**NO**	**DON'T KNOW**
1. Is the minor feeling sick today? (i.e. fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea)	☐	☐	☐
2. In the past 10 days, has the minor tested positive for COVID-19 infection or is he/she currently being monitored for COVID-19 infection (e.g. in quarantine)?	☐	☐	☐
3. Has the minor had an allergic reaction to 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 intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Has the minor ever had an allergic reaction to another vaccine or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused him/her to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐

5. Check all that apply to the minor receiving the vaccine:

☐ Male between ages 12 and 39 years old
☐ Has a history of myocarditis or pericarditis
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet venom, environmental or oral medication allergies
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a history of thrombosis with thrombocytopenia following an adenovirus-vectored vaccine (e.g. Johnson & Johnson, Astrazeneca or Sputnik COVID-19 vaccines)
☐ Has a bleeding disorder
☐ Takes a blood thinner
☐ Has a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Is currently pregnant or breastfeeding
☐ Has received dermal fillers
☐ Have a history of Guillain-Barré Syndrome (GBS)
☐ Have received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies

Note: Please continue to page 2.

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD	
COVID-19 Vaccine: Primary Series: ☐ Dose 1 ☐ Dose 2 ☐ Dose 3 ☐ Dose 4 Bivalent Booster: ☐ Dose 1	Date Administered: Dose: _____mL Route: Intramuscular (IM)
Manufacturer: ☐ Pfizer Maroon Cap (6 months-4 years) ☐ Pfizer Orange Cap (5-11 years) ☐ Pfizer Gray Cap (12 years +) ☐ Novavax	Site: ☐ Left Deltoid ☐ Right Deltoid ☐ Left Anterolateral Thigh ☐ Right Anterolateral Thigh
Lot #: Expiration Date: EUA Fact Sheet or VIS Given: ☐ Yes ☐ No	Vaccine Administered By Print Name: Signature:
VIS Date:	Title: ☐ RN ☐ LVN ☐ Pharmacist ☐ _____

Section 3 – Information on the risks and benefits of the COVID-19 vaccine

- COVID-19 vaccines are authorized for use through a full-approval or an emergency use authorization (EUA) issued by the U.S Food and Drug Administration (FDA).
- The FDA-approved Comirnaty (COVID-19 Vaccine, mRNA) and the FDA-authorized Pfizer-BioNTech COVID-19 Vaccine have the same formulation and may be used interchangeably in minors aged 12 years or older to provide the COVID-19 vaccination series.
- The COVID-19 vaccine has shown to be effective at helping to protect against severe disease and death caused by SARS CoV-2.
- All vaccines have risks and side effects, and there may be risks that are not known yet.
- To learn more about the risks and benefits of the COVID-19 vaccine, read the appropriate fact sheet based on the authorized age group below:

	COVID-19 VACCINE INFORMATION			
	AUTHORIZED AGE GROUP	**PRIMARY SERIES**	**INTERVAL**	**FACT SHEET**
☐	**Pfizer-BioNTech 12 years of age and older (Primary Series and Bivalent Booster)**	**2 doses**	**3-8 weeks**	
☐	**Pfizer-BioNTech 5 to 11 years of age**	**2 doses**	**3-8 weeks**	
☐	**Pfizer-BioNTech 6 months to 4 years of age**	**3 doses**	**Dose 1 to 2 (21 days) Dose 2 to 3 (8 weeks)**	
☐	**Novavax 12 years of age and older**	**2 doses**	**3-8 weeks**	

***Note**: After completion of the primary series, individuals may be eligible for a booster or an additional dose.*

Section 4 – Consent

I have reviewed the information on the COVID-19 Vaccine in Section 3. I understand and agree that:

- I have had the chance to ask questions that were answered to my satisfaction.
- I have the legal authority to consent to have the child named in section 1 to be vaccinated with the COVID-19 vaccine.
- Children aged 17 years and younger may receive the COVID-19 vaccine only with a parent or legal guardian present.
- The minor must remain on site for 15 minutes after receiving the vaccine or 30 minutes if there is a history of previous anaphylactic reactions or other risk factors.
- As required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record.
- By signing this form, I give San Bernardino County and participating vaccination partner's permission to contact me regarding COVID-19 vaccine reminders and access to electronic vaccination records for the child.
- I will not have to pay for either the COVID-19 vaccine or the cost of administering the vaccine. If I have health insurance, I understand that my insurance company may be billed for the costs of administering the vaccine and a copy of my health insurance information will be collected.

☐ **By checking the box, I give consent for the child named in Section 1 of this form to be vaccinated with the COVID-19 vaccine.** I release San Bernardino County, its employees, and representatives from any liability or further responsibility with regard to receiving the vaccine.

Section 5 – Parent or guardian information and signature of consent

Parent/Guardian Last Name	*Parent/Guardian First Name*	*Parent/Guardian Middle Name*
Parent/Guardian Signature	*Parent/Guardian Relationship to Child*	*Date*
Address (if different from above)		

SELF-ATTESTATION OF EMANCIPATION ONLY

☐ By checking this box, I attest that I am legally emancipated minor, married or previously married.

Signature of Emancipated Minor	*Date*

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