SCREENING QUESTIONNAIRE: PFIZER 5-11 IMMUNIZATIONS

PATIENT NAME: ____________________________ ADDRESS ____________________________

BIRTHDATE: ____________________________ CITY, STATE, ZIP: ______________________

PHONE:____________________________________ ALLERGIES: ___________________________

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INSURANCE:_______________________________ PCP:___________________________________

Is the child sick today?		
Does the child have allergies to medications, food, a vaccine component, or latex?		
Has the child ever had a serious reaction after receiving a vaccination?		
Has the child ever had an anaphylactic reaction due to any cause?		
In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs: drugs for the treatment of Rheumatoid arthritis, Crohn's disease or psoriasis; or had radiation treatments?		
Has the child received antibody or convalescent plasma therapy in the last 90 days to treat COVID-19?		
Has the child received the first dose of the COVID-19 vaccine?		

If you answered yes to the question above:
What date did you receive the first COVID-19 vaccine:________________

Authorization to Administer COVID Vaccine:
I have read or had explained to me, and I understand the risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

Patient OR
Parent/Guardian Signature: ____________________________________ Date: ________

Parent name (please print): ____

Pfizer-BioNTech COVID-19 Vaccine for 5-11 NDC: 59267-1055-04 **Lot:** _________________ **EXP:** ___________________ **Volume: 0.2mL**	SITE: L delt/ R delt EUA Date: 10/29/2021
FORM REVIEWED BY/Administered By and Title:	EUA GIVEN DATE/ DATE: