COVID-19 VACCINE 16+ CONSENT FORM

Consent to Administer COVID-19 vaccine

Dayton Children's Hospital 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 1st and 2nd DOSE of COVID-19 VACCINE

SCHOOL NAME:			**GRADE:**
PLEASE PRINT PATIENT INFORMATION			
STUDENT NAME (Last Name)	**(First Name)**	**(M.I.)**	**Patient Age** 16 17 18 or over
Date of Birth:	**Sex:** ☐ Male ☐ Female ☐ Other	**Ethnic Group:** ☐ Hispanic ☐ Non-Hispanic	Parent/Guardian (if different than patient):

Race: ☐ Alaskan Native ☐ AM-American Indian ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Prefer Not to Disclose ☐ Unknown

Street Address: **Apt #:**	**City:**	**State:**	**County:**	**Zip Code:**
Home Phone:	**Alternate/Cell Phone:**	**Email Address:**		

EMERGENCY CONTACT:
Name:_____ **Relationship:**_____ **Phone Number:** _____

Are we able to leave messages with your emergency contact? ☐ **Yes** ☐ **No**

PRESCREENING QUESTIONS:

1.	Has the child tested positive for COVID-19 in the past 10 days?	☐ Yes	☐ 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 taste, sore throat or runny nose?	☐ Yes	☐ No
3.	Is the child currently under quarantine by the health department (includes notices by school/daycare workplace) for COVID-19 exposure?	☐ Yes	☐ 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?	☐ Yes	☐ No
5.	Has the child received any vaccine in the past 14 days?	☐ Yes	☐ No
6.	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?	☐ Yes	☐ No
7.	Has the child received the first dose of the COVID vaccine? If yes, when and where?	☐ Yes	☐ No

Where: _____ When:_____

If you answered "Yes" to questions 1,2,3,4, 5 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.

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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 Dayton Children's Hospital, hereafter referred to as "DCH" 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 Dayton Children's COVID-19 hotline team by calling 1-888-746-KIDS (5437).

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 DCH, 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:_____

For Administrative Use:

Manufacturer	Pfizer
Lot # Dose 1:_____	Exp Date Dose 1:___/___/____
Date of Administration Dose1 ____/____/____	Site of Administration Dose 1 Left Arm / Right Arm
Lot # Dose 2:_____	Exp Date Dose 2: ___/___/___
Date of Administration Dose 2 ____/____/____	Site of Administration Dose 2 Left Arm / Right Arm