Cornell Scott Hill Health Center

Patient's MRN Number: _____
Patient Name: _____
Patient Date of Birth: _____
Parent/Guardian Name: _____
Parent/Guardian Phone Number: _____

CONSENT FOR COVID-19 VACCINATION SERIES

Please answer the following questions:

1. Has your child ever received a dose of COVID-19 Vaccine?

   ☐ No ☐ Yes, the Moderna

   ☐ Yes, the Pfizer-BioNTech ☐ Yes, the Janssen (Johnson & Johnson)

   ☐ Yes, unsure which COVID-19 vaccine **IF YES PLEASE LIST THE DATE(S) HERE: _____**

2. Has your child ever had an allergic reaction or severe allergic reaction to any previous vaccine or any component of the COVID-19 Vaccine? ☐ **Yes** ☐ **No**
3. Has your child ever had a severe allergic reaction* to something other than a vaccine (Including food, pet, environmental, or oral medications)? ☐ **Yes** ☐ **No**
   **(A severe allergic reaction includes a reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital*)
4. **Please choose one of the options below or call the School Based Health Center with any questions**
   - ☐ **I wish to be present** at the time my child will receive the vaccine.
     *A member of the school based staff will call to set up an appointment time for you.
   - ☐ **I do not need to be present** when my child receives the vaccine.
     *A letter will be sent home with your child when they receive the vaccine at the School Based Health Center.

I have received the Emergency Use Authorization (EUA) Fact Sheet for the COVID-19 Vaccine. I understand the COVID-19 vaccine has potential side effects including a remote risk of more severe or unexpected side effects. I understand that the emergency use of the COVID-19 vaccine has been authorized by the United States Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA). I have read the EUA fact sheets for the vaccine that the person named above, and for whom I am the legal guardian ("Ward"), may receive. I understand the risks as outlined in the fact sheet. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from the receipt of the immunization(s) by my Ward. I have had an opportunity to ask questions about this immunization. I understand the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization be given to my Ward. On behalf of my Ward, hereby release the provisioning vaccination site, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to the receipt of these immunization(s). Neither the provisioning mass vaccination center nor any of the released parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. The provisioning vaccination center may use and disclose the personal and health information of my Ward, to treat, receive payment of the care provided, and for other healthcare operations.

If the individual named above is my minor child, I agree and consent to such minor receiving the COVID-19 vaccine available at the vaccination site without my presence. I understand that my child will be asked several basic screening questions regarding my child's current health status. I further acknowledge that my child is capable of responding fully and honestly to these questions and of following all instructions provided at the time of vaccination, including the mandatory 15- or 30-minute post-vaccination monitoring period.

By signing below I attest that I am 18 or older and consenting for myself or I am the legal guardian of the patient named above. I consent for my minor child to receive the COVID-19 immunization(s).

I understand that the COVID 19 vaccine is a multi-dose series. I am giving consent for both the first and second dose to be administered in accordance with the most current Emergency Use Authorization. I am also giving consent for subsequent booster doses of the COVID 19 vaccine to be administered at the approved interval timing based on guidance by the CDC and FDA.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Print Patient or Guardian: Last Name, First Name, Middle Initial Relationship to Patient