Consent and Administration Record – Gundersen Tri-County Hospital and Clinics School-Based COVID-19 Immunization Clinic

Facility Address: 18601 Lincoln Street Whitehall, Wi. 54773 Phone: (715) 538-4361

Name of my Child's School: _____ Grade: _____

Information about Student Receiving Vaccine(s) – Please Print			
Student Last Name:	**First Name:**		**MI:**
Street Address:	**City:**	**State:** WI	**Zip:**
Date of Birth (MM/DD/YY):	**Age:**	**Mother's Maiden name**	
Gender: ☐ Male ☐ Transgender – Male to Female ☐ Transgender – Female to Male ☐ Female ☐ Transgender – Unspecified or Gender Non-Specific ☐ Prefer not to Answer ☐ Other _____			
Race: (check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ African American or Black ☐ Native Hawaiian or other Pacific Islander ☐ Prefer not to Answer ☐ Other_____ ☐ Multi-race			**Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to Answer
Parent / Legal Guardian Last Name:	**First Name:**		**Phone Number:** (Where you can be reached on date of clinic)

By my signature below, I consent for Gundersen Tri-County Hospital and Clinics to bill my insurance company.
Medicare#:_____
If you are not on Medicare OR have a Medicare Supplemental/Advantage, please include that information here:
Insurance Company:_____ Mailing Address:_____
Policy Holder/Subscribers Name:_____ ID#:_____ Group #:_____
Type of Insurance: ☐ Commercial ☐HMO ☐Medicare ☐Medicare Advantage ☐Medicare Supplemental ☐Badgercare

I understand the benefits and risks of the vaccine and ask that the vaccine be given to the child listed above for whom I am authorized to make this request.

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks)**

The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety.

	Questions about the student receiving vaccine:	**Yes**	**No**
1	Is the student currently in isolation or quarantine period due to COVID-19?		
2	Has the student ever received a dose of COVID-19 vaccine?		
3	Has the student ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:_____		
4	Has the student received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
5	Has the student received any vaccines in the past 14 days?		
6	Is the student pregnant or breastfeeding?		

_____ _____
Signature of Parent/Legal Guardian Date Signed

_____ _____
Printed Name of Parent/Legal Guardian Relationship to Child

For Office Use Only

Date/Time	Dose	Vaccine	Lot Number	Expiration Date	Site	Signature & Title – person administering vaccine
	☐ 1ST Dose ☐ 2nd Dose	Pfizer COVID-19 0.3 mL IM			☐ RD ☐ LD	

Second Dose Information: **Date**: _____**Time**:_____ **am/pm**

Comments:

Date EUA fact sheet for recipients and caregivers provided to parent/guardian: