



Pediatric COVID-19 Vaccination Agreement

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Please answer the following questions:

**Today**, does the patient have any of the following symptoms?

- Fever (temperature greater than 100.4°F)       Yes       No
- Loss of taste and or smell       Yes       No
- Cough and or shortness of breath       Yes       No
- Nausea, vomiting, diarrhea       Yes       No
- Any other flu like symptoms       Yes       No

**Has the patient ever** had a serious reaction to a vaccination or medication in the past (anaphylaxis, swollen lips, tongue, throat, etc.) requiring medical treatment or emergency evaluation?       Yes       No

Attestation Acknowledgment and Signature:

- I attest and represent that the patient meets at least one of the currently applicable vaccination eligibility criteria as set forth by the PA Department of Health.
- I understand that it is not possible to consider every possible side effect/complication to vaccination.
- I have had an opportunity to ask questions regarding the vaccination and my questions have been answered to my satisfaction.
- I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to my child or ward.
- I acknowledge that I have received the Notice of COVID-19 Immunization and Reporting Requirements and consent to informing the PA State Immunization Registry that my child or ward has received the COVID-19 vaccine.

Parent or Legal Guardian Printed Name: \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Vaccinator Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_