TANQUE VERDE PEDIATRICS

IN OFFICE USE ONLY	
15	30
LD	RD
INITIALS: _____	

COVID-19 VACCINE CONSENT FORM

PATIENT NAME: _____ **DOB:** _____/_____/_____ **AGE:** _____

PCP: _____

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY

☐ MODERNA		☐ PFIZER	
HAS THE CHILD TO BE VACCINATED:	**YES**	**NO**	**DON'T KNOW**
Felt Sick today?	YES	NO	DON'T KNOW
Received a prior COVID Vaccine?	YES	NO	DON'T KNOW
Ever had anaphylaxis to anything?	YES	NO	DON'T KNOW
Had/Has a bleeding disorder?	YES	NO	DON'T KNOW
Had/Has a history of myocarditis?	YES	NO	DON'T KNOW
Had COVID monoclonal antibody treatment?	YES	NO	DON'T KNOW
Been diagnosed with MIS-C?	YES	NO	DON'T KNOW
Taken/Taking a blood thinner?	YES	NO	DON'T KNOW

I have reviewed the EUA and consent to vaccination for my child, named above. **Please see our website for the EUA links for your child's age group and type of vaccine.

Parent Signature: _____ **Parent Printed Name:** _____

Date of Vaccination: _____

PLEASE PRINT OUT FORM FOR **EACH CHILD TO BE VACCINATED AND BRING IN ON YOUR VACCINATION DATE. PLEASE BRING A MASK FOR EACH PERSON COMING INTO THE CLINIC. THANK YOU

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