Columbia/Boone County Public Health & Human Services
1005 West Worley | Columbia, MO 65203
Phone: 573-874-7356

COVID-19 School-Based Vaccination Consent under Emergency Use Authorization

SECTION 1: INFORMATION ABOUT THE CHILD TO RECEIVE VACCINE (PLEASE PRINT)

STUDENT'S NAME (Last)		(First)		(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER**

STUDENT'S DATE OF BIRTH **MONTH _____ DAY _____ YEAR _____**		**SCHOOL NAME/GRADE/TEACHER**

DOES THE STUDENT HAVE HEALTH INSURANCE: ❑ Yes ❑ No ❑ Insured Through Medicaid (MO Health Net)	**STUDENT NUMBER**	

STUDENT'S ADDRESS	**CITY**	**STATE**	**ZIP**

PARENT/GUARDIAN DAYTIME PHONE NUMBER(S):	**PARENT/GUARDIAN <u>EMAIL ADDRESS</u>** (Optional)	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)

SECTION 2: HEALTH HISTORY

	YES	NO	DON'T KNOW
1. Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, or polysorbate, or a previous dose of COVID-19 vaccine? (This would include a severe allergic reaction [e.g. anaphlyaxis that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occured within 4 hours that cause hives, swelling, or respiratory distress, incluidng wheezing.)			
2. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
4. Have you received any vaccine in the last 14 days?			
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
7. Do you have a weakened immune system cause by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have have a bleeding disorder or are you taking a blood thinner?			

SECTION 3: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals who sustain a covered serious physical injury as the direct result of the adiminstration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-bionetch-covid-19-vaccine.
For your review, the Emergency Use Authorization (EUA) can be found online at https://bit.ly/2S3yzKu and the Notice of Privacy Practices from Missouri DHSS can be found at https://bit.ly/3nmdSF6. There are also QR codes for each document on the other side of this form.

I acknowledge and agree that I have received or have been advised of the Missouri Department of Health and Senior Services' Notice of Privacy Practices and where I can obtain any revisions made to this notice. I also acknowledge I have been given a copy and have read, or had explained to me, the fact sheet/Emergency Use Authorization (EUA) for the vaccine being given today. I understand the benefits and risks of the vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. ***I understand that this consent applies to both doses of the COVID-19 vaccine unless I contact the school to revoke consent.***

AUTHORIZED SIGNATURE	**RELATIONSHIP TO CLIENT**	**TODAY'S DATE**

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For Clinic Use Only

SECTION 4: VACCINATION RECORD - FOR CLINIC USE ONLY

Manufacturer	**Brand**	**Lot number**
Dose number **1 ❑ or 2 ❑**	***Exp. Date:**	***Date Administered:**
***EUA fact sheet date:**	**Injection Site (Deltoid)** **L ❑ R ❑**	**Dose: ❑ 0.3 ml** **❑ 0.5 ml**
***Administered by Name & Title:**		

Second Dose:

Manufacturer	**Brand**	**Lot number**
Dose number **1 ❑ or 2 ❑**	***Exp. Date:**	***Date Administered:**
***EUA fact sheet date:**	**Injection Site (Deltoid)** **L ❑ R ❑**	**Dose: ❑ 0.3 ml** **❑ 0.5 ml**
***Administered by Name & Title:**		

Information for healthcare Professionals about the health history for COVID-19 vaccines

1.Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, or polysorbate, or a previous dose of COVID-19 vaccine? History of severe allergic reaction (anaphylaxis) or immediate allergic reaction after a previous dose of an mRNA Covid-19 vaccine or any of its components (including polyethylene glycol, or polysorbate) is a contraindication for either of the mRNA Covid-19 vaccines.

2.Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? A history of any immediate allergic reaction to any other vaccine or injectable therapy (i.e., intramuscular, intravenous, or subcutaneous vaccines or therapies not related to a component of mRNA COVID-19 vaccines or polysorbate) is a precaution to currently authorized COVID-19 vaccines.

3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. Allergic reactions, including severe allergic reactions, NOT related to vaccines or injectable therapies (e.g., food, pet, venom, environmental, or latex allergies; oral medications) are NOT a contraindication or precaution to vaccination with currently authorized COVID-19 vaccine. HOWEVER, individuals who have had severe allergic reactions to something, regardless of cause, should be observed for 30 minutes after vaccination. All other persons should be observed for 15 minutes

4. Have you received any vaccine in the last 14 days? Given the lack of data on the safety and efficacy of mRNA Covid-19 vaccines administered simultaneously with other vaccines, the vaccine series should be administered alone, with a minimum interval of 14 days before or after administration of any other vaccines.

5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Vaccination should be offered to persons regardless of history of prior SARS-CoV-2 infection. Vaccination should be deferred until the person has recovered from the acute illness and criteria have been met for them to discontinue isolation.

6. Have you received passive antibody therapy as a treatment for COVID-19? Based on the estimated half-life of monoclonal antibodies or convalescent plasma as part of COVID-19 treatment, as well as evidence suggesting that reinfection is uncommon in the 90 days after initial infection, vaccination should be deferred for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses

7. Do you have a weakened immune system cause by something such as HIV infection or cancer or do you take immunosuppresive drugs or therapies? Taking mediation or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system is not a contraindication to current COVID-19 vaccine, including those with cancer, leukemia, HIV/AIDS and other immune system problems or taking medication that affects their immune systems. However, patients should be informed that the vaccine might be less effective than in someone who is immunocompetent.

8. Do you have a bleeding disorder or are you taking a blood thinner? COVID-19 vaccine may be given to these patients, if a physician familiar with the patient's bleeding risk determines that the vaccine can be administered intramuscularly with reasonable safety. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

Privacy Practice QR code:

Pfizer EUA QR code: