

**Attestation For Administration of COVID-19 Vaccine to Minors Per Emergency Use  
Authorization (Please PRINT Clearly)**

**Minor Full Legal Name:** \_\_\_\_\_

**Parent/Legal Guardian Contact Information:**

**Minor Date of Birth** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

**Phone Number:** ( \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ )

**Minor Race (Check One):**

**Minor Ethnicity (Check One):**

- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander

- Hispanic or Latino
- Not Hispanic or Latino

**Email Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

*Street Address*

*City, State, Zip Code*

**Minor Sex (Check One):**  Male  Female

**Target Population or Occupation:** \_\_\_\_\_

**Vaccination Location:** \_\_\_\_\_

- 
1. Does the minor currently have an active infectious or acute respiratory illness, or fever?  Yes  No
  2. Has the minor ever had a severe allergic reaction to any of the vaccine ingredients listed in the EUA Fact Sheet or in other vaccine documents provided to you?  Yes  No
  3. Has the minor received any other vaccines within the past 14 days?  Yes  No
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I understand that the COVID-19 vaccine the minor above is receiving is being administered to the minor above pursuant to a U.S. Food and Drug Administration Emergency Use Authorization (EUA). I have received and read the EUA Fact Sheet for recipients of this vaccine (and/or other vaccine documentation provided to me), which fully explains to me the risks and benefits of receiving this vaccine. I agree that Hamilton County Public Health (HCPH) has not made any guarantees to me or the minor above about the result(s) of this vaccination, and I understand that the minor above may experience side effect(s) after receiving this vaccine. Depending on the vaccine manufacturer, I further understand that if this vaccine needs to be administered as a 2-dose series, I agree that I will promptly schedule the minor above's second-dose appointment as indicated.

I agree that it is my personal decision to have the minor above receive this EUA COVID-19 vaccine, and I give HCPH permission to administer this vaccine to the minor above. By signing below, I further confirm that: the minor above is 12 years of age or older, I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by HCPH have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the parent or legal guardian of the minor listed above and that I have signed this Attestation voluntarily.

Signature of patient or parent/legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of patient or parent/legal guardian: \_\_\_\_\_

FOR OFFICE USE ONLY Vaccine Administered Per EUA					_____	
Vaccine Manufacturer:	Pfizer-BioNTech	Moderna	<input type="checkbox"/> AstraZeneca	<input type="checkbox"/> Other	DOSE 1 Lot # _____	
Route/Site:	<input type="checkbox"/> IM - Left Deltoid	<input type="checkbox"/> IM - Right Deltoid		Exp. Date _____		
Vaccine Documents provided by BSMH:	<input type="checkbox"/> EUA Fact Sheet for Recipient		<input type="checkbox"/> Vaccination record card		DOSE 2 Lot # _____	
					Exp. Date _____	
DOSE 1 Administered by (PRINT FULL NAME): _____			DOSE 2 Administered by (PRINT FULL NAME): _____			
Administrator Signature: _____			Administrator Signature: _____			
Date/Time Administered Dose 1: _____			Date/Time Administered Dose 2: _____			

# Prevaccination Checklist for COVID-19 Vaccines



## For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

Patient Name \_\_\_\_\_

Age \_\_\_\_\_

**If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked.

If a question is not clear, please ask your healthcare provider to explain it.

Yes No Don't know

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> <li>If yes, which vaccine product did you receive?                               <input type="checkbox"/> Pfizer    <input type="checkbox"/> Moderna    <input type="checkbox"/> Another product _____                         </li> </ul>			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> <li>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</li> </ul>			
<ul style="list-style-type: none"> <li>Polysorbate</li> </ul>			
<ul style="list-style-type: none"> <li>A previous dose of COVID-19 vaccine</li> </ul>			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. 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.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by \_\_\_\_\_

Date \_\_\_\_\_