HAMILTON COUNTY PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Attestation For Administration of COVID-19 Vaccine to Minors

(Please PRINT Clearly)

Minor Full Legal Name: _____

Minor Date of Birth _____/_____/_____
MM DD YYYY

Minor Race (Check One):
❑ White
❑ Black or African American
❑ Asian
❑ American Indian or Alaska Native
❑ Native Hawaiian or Other Pacific Islander

Minor Ethnicity (Check One):
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Minor Sex (Check One): ❑ Male ❑ Female

Target Population or Occupation: _____

Parent/Legal Guardian Contact Information:

Phone Number: (_____-_____-_____)

Email Address: _____

Address: _____
Street Address

_____
City, State, Zip Code

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

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 (FDA) Emergency Use Authorization (EUA) for minors aged 5-15 years and pursuant to FDA approval to minors aged 16-17 years. I have received and read the EUA Fact Sheet or Vaccine information 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 to receive a second-dose as indicated.

I understand that the minor above may be eligible to receive a gift card incentive (while supplies last) when receiving their 1st COVID-19 vaccination with HCPH.

I agree that it is my personal decision to have the minor above receive this EUA COVID-19 vaccine for minors aged 5-15 years and FDA-approved vaccine for minors aged 16-17 years, and I give HCPH permission to administer this vaccine to the minor above. By signing below, I further confirm that: the minor above is 5 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	❑ AstraZeneca	❑ Other	DOSE 1 Lot # _____
Route/Site:	❑ IM - Left Deltoid	❑ IM - Right Deltoid			Exp. Date _____
Vaccine Documents provided by BSMH:	❑ EUA Fact Sheet for Recipient		❑ Vaccination record card		DOSE 2 Lot # _____ Exp. Date _____
DOSE 1 Administered by (PRINT FULL NAME): _____ Administrator Signature: _____ Date/Time Administered Dose 1: _____			DOSE 2 Administered by (PRINT FULL NAME): _____ Administrator Signature: _____ Date/Time Administered Dose 2: _____		

Last edited 3/17/21__4/15/2021JLM_4/20/21JDS_8/26/21JDS_11/1/21JDS

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
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
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.)			
• 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			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
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** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists