Tender Care Pediatrics
2322 New Road Northfield NJ 08225
(609)641-0200

COVID-19 Immunization Screening and Consent Form*

Section 1: Demographic Information (PLEASE PRINT):			
Name (Last)	(First)	(M.I.)	M/F AGE:_____ DOB:_____
Mailing Address: (Street/PO Box, City, State, ZIP)			
Phone Number:	County:	Municipality:	

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

Section 2: Screening Questionnaire: **(Please mark YES or NO for each of following questions):**	**YES**	**NO**
1) Are you sick today?		
2) Have you ever received a dose of COVID-19 vaccine?		
If yes, which vaccine product? □ Pfizer □ Moderna □ Another product		
3) Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? • Was the severe allergic reaction after receiving a COVID-19 vaccine? • Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
4) Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
5) Have you received another vaccine in the last 14 days?		
6) Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
7) Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
8) Do you have a bleeding disorder or are you taking a blood thinner?		
9) Are you pregnant or breastfeeding?		

Section 3: Consent for Vaccination:

I have been provided and have read, or had explained to me, the information sheet (Emergency Use Authorization [EUA]) about the COVID-19 vaccination. I understand that this vaccine requires two doses and two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I GIVE CONSENT to the Atlantic County Division of Public Health and associated staff to administer this vaccine to me. The information gathered may be used for vaccine administration reimbursement at no cost to me. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. I authorize release of all information needed for public health purposes, including reporting to applicable vaccine registries (including but not limited to NJ Immunization Information System [NJIIS], NJ Vaccine Scheduling System [NJVSS]).

□ I understand or have been explained the above information and I was given the opportunity to ask questions.

Signature of Vaccinee/Surrogate/Guardian: _____ Date: _____
Print Name of Vaccinee: _____

PLEASE DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATION USE ONLY.

Vaccine	Brand	Date Dose Administered	Route (IM, SC)/ Site (RA, LA)	Staff Initial/ Title	Dose Number	Lot Number	Exp Date	EUA Fact Sheet Date
COVID-19	□ Pfizer □ Moderna □ Another product							

* Use of this form is optional.

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