Covid-19 Pre-Vaccination Form and Documentation

School District: _____

Name: _____ **Date of Birth:** _____
First and Last Name Month/Date/Year

Address: _____ **City:** _____ **Zip:** _____

Parent/Guardian Name: _____ **Emergency Phone #:**_____

Gender: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Multi-racial or other ☐ Decline to answer

Please answer the following screening questions:

1) I hereby certify that I have read the Pfizer Fact Sheet for Emergency Use Authorization (file attached to email)
   ☐ Yes

2) Please indicate your age range:
   ☐ under age 11 ☐ 12 to 15 ☐ 16 to 49 ☐ 50 to 64 ☐ 65 and older

3) Have you ever had a life-threatening allergic reaction to any vaccine?
   ☐ Yes ☐ No

4) Do you currently have an acute illness and/or high fever?
   ☐ Yes ☐ No

5) Do you have any of the following chronic illnesses?
   Asthma, cancer, chronic liver disease, chronic lung disease, heart disease, diabetes, kidney dysfunction
   ☐ Yes ☐ No

6) Do you have current or planned immunosuppression?
   HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent or prednisone = 15 mg/day for =1 month) or other immunosuppressive medication
   ☐ Yes ☐ No

7) Have you received any other vaccinations in the past 30 days?
   ☐ Yes ☐ No

8) Are you pregnant at this time or do you plan to become pregnant in the next 2-months?
   ☐ Yes ☐ No ☐ Not Applicable

9) Are you currently breastfeeding?
   ☐ Yes ☐ No ☐ Not Applicable

10) I want to receive the Covid-19 vaccination. I hereby certify that I have carefully read this Covid-19 Immunization Survey, that I understand it and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered.

Student Signature (if 18 years or older) Date	Signature of Parent/Guardian Date Print Name of Parent/Guardian

To be completed at the Clinic:

FIRST DOSE:

Vaccine Administered	Mfg.	Lot #	Exp. Date	Site
Covid-19	**Pfizer**			L R Upper arm

Clinic Location: Akron Children's Hospital, School Health Services

NURSE SIGNATURE_____ **DATE:** _____

NURSE PRINT_____

SECOND DOSE:

Vaccine Administered	Mfg.	Lot #	Exp. Date	Site
Covid-19	**Pfizer**			L R Upper arm

Clinic Location: Akron Children's Hospital, School Health Services

NURSE SIGNATURE_____ **DATE:** _____

NURSE PRINT_____