Clark County Health Department 517 Court Street, Room 105 | Neillsville, WI 54456

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PFIZER PEDIATRIC (AGES 5-11) COVID-19 VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of the COVID-19 vaccine, and will be shared through the Wisconsin Immunization Registry (WIR). Information collected on this form is voluntary and confidential.

Please answer the following questions:	**Yes**	**No**
1. Is the child currently experiencing a moderate or severe acute illness with or without fever?		
2. Does the child have a history of severe allergy reaction (e.g. anaphylaxis) to an injectable medication?		
3. Is the child immunocompromised?		
4. Has the child been instructed by public health to isolate or quarantine at this time, due to COVID-19 infection or exposure?		
5. Has the child received passive antibody therapy for COVID-19 within the last 90 days?		
6. Does the child have a history of being diagnosed with MIS-C (Multisystem Inflammatory Syndrome in Children)?		

7. What dose of the PEDIATRIC PFIZER COVID-19 vaccine is the child receiving?

CIRCLE: **DOSE 1 (skip a & b below)** **DOSE 2 (complete a & b below)**

a. If the child received DOSE 1, what date did they receive the vaccine? **DATE:** / /

b. If the child received DOSE 1, did they experience a serious reaction (e.g. anaphylaxis) to the COVID-19 vaccine or to any of its components? CIRLCE: **YES** **NO**

Information about the child receiving the COVID-19 vaccine (please print):

Last Name: **First Name:** **M.I.** **Age:**

Date of Birth - Month: Day: Year: **Sex:** Male / Female / Other

Ethnicity: Hispanic / Not Hispanic **Race:** White / African American / Asian / Other

Address: Street **City** **County** **Zip Code** **Phone #**

1) I have been given a copy and have read, or have explained to me, the information in the Pfizer Pediatric (ages 5-11) COVID-19 vaccine Emergency Use Authorization (EUA) fact sheet. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of my child receiving the COVID-19 vaccine. I have been made aware of the appropriate time my child is expected to be monitored for post-vaccination reactions based on their risk factors. I request that the COVID-19 vaccine be given to my child or person named below for whom I am authorized to make this request. 2) By signing this form, I authorize the Clark County Health Department to release the necessary information to the insurance carrier indicated below, to process this claim. I understand I will not be held responsible to pay the fee for the COVID-19 vaccine if my insurance carrier denies payment or if I have an insurance carrier that the CCHD does not accept.

Signature of Parent or Legal Guardian

X _____

Date:

STOP - FOR CLINIC/OFFICE USE ONLY			
Vaccine Name: PFIZER	**Lot/Exp. Date:**	**Dose: 0.2 mL**	**Injection Site:** **RD / RV / LD / LV**
Signature & Title of Vaccine Administrator:		**Date:**	
☐ **WIR** ☐ **Billed**			*Updated: 11/08/2021*
INSURANCE INFORMATION			
Primary Insurance Carrier Provider:			
Member ID / Subscriber or ID #:			
Secondary Insurance Carrier Provider (if applicable):			
Member ID / Subscriber or ID # for Secondary Insurance (if applicable):			