SAN BERNARDINO COUNTY | Public Health

COVID-19 Vaccination Minor Consent Form

Patient Information (please print):		
Minor's Last Name	*Minor's First Name*	*Minor's Middle Name*
Date of Birth (MM/DD/YYYY)	*Minor's Age*	*Parent/Guardian Phone Number*
Street Address, City, State, Zip		*Parent/Guardian Email*
Mother's Maiden Name (Maiden Last Name, First Name)		

Gender: (Check one)	*Race: (Check one)*			*Ethnicity: (Check one)*
☐ Female ☐ Non-Binary	☐ American Indian	☐ White	☐ Other Pacific Islander	☐ Hispanic
☐ Male ☐ Unknown	☐ Alaska Native	☐ Black or African American	☐ Decline to Answer	☐ Non-Hispanic
☐ Decline to Answer	☐ Asian	☐ Native Hawaiian	☐ Other _____	☐ Decline to Answer

Patient Eligibility Status Verification: These questions are to assess your child's health insurance status and extent of coverage to help determine if eligibility criteria are met for COVID-19 vaccines through our various programs. This **will NOT** affect access to COVID-19 vaccines today.

The patient named above qualifies for COVID-19 immunization through the **Vaccines for Children (VFC) Program** because he/she/they or his/her/their parent/guardian states that the child is 18 years of age or younger and: **(Choose only one of the following. If a child meets two or more of the eligibility qualifications, choose the first that applies.)**

☐ Is Medi-Cal or Child Health and Disability Prevention (CHDP) Program eligible; or
☐ Is uninsured (does not have private insurance); or
☐ Is American Indian or Alaskan Native.

The patient named above qualifies for COVID-19 immunization through **San Bernardino County Public Health Immunizations Program** because he/she/they or his/her/their parent/guardian states that the child:

☐ Has health insurance that pays for vaccines.

Screening Questions

	YES	NO	UNKNOWN
1. Is the minor feeling sick today? (i.e., fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea)	☐	☐	☐
2. Has the minor had an allergic reaction to a component in a COVID-19 vaccine, including:			
• Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐

3. Check all that apply to the minor receiving the vaccine:
   - ☐ Male between ages 12 and 39 years old
   - ☐ Has a history of myocarditis or pericarditis
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Has a bleeding disorder
   - ☐ Takes a blood thinner
   - ☐ Vaccinated with monkeypox (Mpox) in the last 4 weeks
   - ☐ Has a weakened immune system (i.e., HIV infection, cancer) or takes immunosuppressive drugs or therapies
   - ☐ Has received dermal fillers
   - ☐ Have received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies

Note: Please continue to page 2.

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Patient Eligibility: _____

Initials: _____

Consent
I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to the person named above for whom I am authorized to make the request. I understand that all vaccines have risks and side effects; and that there may be risks that are not known yet. I attest that, to the best of my knowledge and belief, all information reported in this document is accurate and complete. Children aged 17 years and younger may receive the COVID-19 vaccine only with a parent or legal guardian present. As required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting bit.ly/LockMyCAIRRecord. By signing this form, I give San Bernardino County and participating vaccination partners permission to contact me regarding COVID-19 vaccine reminders and access to electronic vaccination records.
☐ **By checking the box, I give consent for the child named in this form to be vaccinated with the COVID-19 vaccine.** I release San Bernardino County, its employees, and its representatives from any liability or further responsibility concerning receiving the vaccine.

Parent or Guardian Information and Signature of Consent		
Parent/Guardian Last Name	*Parent/Guardian First Name*	*Parent/Guardian Middle Name*
Parent/Guardian Signature	*Parent/Guardian Relationship to Child*	*Date*
Address (if different from above)		

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD	
Vaccine Formulation: ☐ Pediatric 6 months-11 years ☐ Spikevax 12+ years	**Date Administered:** _____ /_____ / _____
Manufacturer: ☐ Moderna	**Dose:** _____mL **Route:** Intramuscular (IM)
Lot #:	**Site:** ☐ Left Deltoid ☐ Left Anterolateral Thigh ☐ Right Deltoid ☐ Right Anterolateral Thigh
Expiration Date:	**Vaccine Administered By**
EUA Fact Sheet or VIS Given: ☐ Yes ☐ No	**Name (please print):** **Signature:**
VIS Date:	**Title:** ☐ RN ☐ LVN ☐ Pharmacist ☐ _____
Vaccine Source: ☐ BAP/317 ☐ PRIVATE ☐ VFC	
Minors Weight (lbs.):	
Previous COVID-19 Vaccine Date:	

Digital Vaccine Record Portal

Immunization Registry Notice to Patients and Parents

Moderna Pediatric 6 months-11 years EUA Fact Sheet for Recipients and Caregivers

Spikevax 12+ years VIS for Recipients and Caregivers