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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

COMIRNATY® COVID-19 PAEDIATRIC (5 to <12 years) Vaccine Consent Form

Please fill in or put label:

Last Name_______________________________

First Name______________________________

Community______________________________

DOB (dd/mm/yyyy)________________________

Please ensure name, community, and date of birth are completed above.

Health card number (if known): ______________________ **House number (optional):** __________________

Phone number: _________________________ **Email address (optional)**: ___________________________

Gender: Boy ☐ Girl ☐ Prefer to self-describe ☐ __________ **Age:** ___________________

Parent/guardian information

Name: ________________________________ **Phone:** _________________________________

For the person receiving the vaccine, please answer the following (space exists for longer comments on the next page):

How many doses of COVID-19 vaccine(s) has your child had before? None ☐ One ☐ Two ☐ Three ☐

If your child has previously received a COVID-19 vaccine, specify the date(s) of the COVID-19 vaccine(s) they have received, if known:

_____/______/______ (dd/mm/yyyy) _____/______/______ (dd/mm/yyyy)

_____/______/______ (dd/mm/yyyy)

		Yes	No
1.	**Is your child feeling sick today?** If yes, please provide details below.	☐	☐
2.	**Has your child had COVID-19?** If yes, please indicate when symptoms started below. *(You can still receive the vaccine if you've had or think you've had COVID-19 before)*	☐	☐
3.	**Has your child recently received specific medications for COVID-19 treatment** (monoclonal antibodies or convalescent plasma)? If yes, please provide date of treatment.	☐	☐
4.	**If your child had a previous COVID-19 vaccine dose, did they have any side effects after that dose?** If yes, please provide details below.	☐	☐
6.	**Does your child have any problems with their immune system or are they taking medications that can affect your immune system (e.g., high dose steroids, chemotherapy)?** If yes, please provide details below. *Ask the health care provider if you are not sure about your child's medical conditions.*	☐	☐

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7.	**Does your child have a bleeding disorder or are they taking any medications that could affect blood clotting?** If yes, please provide details below.	☐	☐
8.	**Has your child ever had a severe allergic reaction for which they were prescribed an Epipen?** If yes, please provide details below.	☐	☐
9.	**Has your child ever had a serious reaction to a vaccine in the past (including allergic reactions, heart inflammation [myocarditis/pericarditis]?** If yes, please provide details below.	☐	☐
10.	**Does your child have an allergy to or could your child be allergic to polyethylene glycol (PEG)?****	☐	☐
11.	**Does your child have an allergy to or could your child be allergic to tromethamine (trometamol, Tris)?****	☐	☐
12.	**Is your child particularly anxious or concerned about receiving their vaccine?** If yes, please provide details below.	☐	☐

** Polyethylene glycol (PEG) can rarely cause allergic reactions and is found in products such as medications, bowel preparation products for colonoscopy, laxatives, cough syrups, cosmetics, skin creams, medical products used on the skin and during operations, toothpaste, contact lenses and contact lens solution.
Tromethamine (trometamol, Tris) may very rarely cause allergic reactions and is found in some medications injected to do tests (contrast media) as well as other medications taken by mouth or injection, and some creams and lotions. Note that this is not a complete list.

Comments from questions above:

CONSENT FOR COMIRNATY® COVID-19 PAEDIATRIC (5 to <12 years) Vaccine:

- I understand the information in the Information Sheet on the COMIRNATY® COVID-19 PAEDIATRIC (5 to <12 years) vaccine.
- I understand the benefits and possible reactions for the COMIRNATY® COVID-19 PAEDIATRIC (5 to <12 years) vaccine and the risk of not getting immunized.
- I have had the opportunity to ask questions and to have them answered to my satisfaction.
- I consent to COMIRNATY® COVID-19 PAEDIATRIC (5 to <12 years) vaccine being given to: My Child ☐ My Ward ☐

Print Name **Signature of Parent/Legal Guardian** **Date (dd/mm/yyyy)**

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First Name______________________________

Community______________________________

DOB (dd/mm/yyyy)________________________

Please indicate your relationship to the child receiving the vaccine: ________________________________

Additional questions to help understand the populations receiving the vaccine:

Underlying medical conditions *Tick all that apply*

heart disease ☐	lung disease ☐	medication that affects immune system ☐
diabetes ☐	kidney disease ☐	problems with the immune system ☐
liver disease ☐	cancer ☐	high blood pressure ☐

For Administrative Use Only:

	DOSE	LOT#	SITE & ROUTE	GIVEN BY & WHEN Name and designation/Date and time
1st Dose	0.2 mL			**Name:**
				Date: *dd /Month / yyyy* **Time:**
2nd Dose	0.2 mL			**Name:**
				Date: *dd/Month/yyyy* **Time:**
3rd Dose	0.2 mL			**Name**
				Date: *dd/Month/yyyy* **Time:**

Comments: