DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Trusted Party Consent and Verification

This form must be completed by the same individual completing the COVID-19 Immunization Screening and Consent Form. Both forms must be complete at time of vaccination.

Consent:

I have the legal authority and have provided consent to the administration of the Pfizer-BioNTech COVID-19 Vaccine to the minor patient,_____, who is between the ages of 5 and 17, to receive the COVID-19 vaccine in the attached *COVID-19 Immunization Screening and Consent Form.*

I understand that the U.S. Food and Drug Administration ("FDA") has authorized the emergency use of the PfizerBioNTech COVID-19 Vaccine, which is not an FDA-approved vaccine. I have been provided access to and read the Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers ("Fact Sheet"). (Read the Fact Sheet at https://www.fda.gov/media/144414/download .)

I understand the known and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine and the extent to which such risks and benefits are unknown.

I hereby authorize_____/_____to
Trusted Party Printed Name Relationship

accompany the above minor child to be vaccinated in my absence and attest that I have completed the COVID-19 Immunization Screening and Consent Form for the above minor child.

Date:_____

_____
Signature
Parent/Legal Guardian/Person *in loco parentis*

_____
Printed Name

Verification:

I,_____, have been authorized to accompany

_____, a minor between the ages of 5 - 17, to receive the COVID-19 vaccination. The parent/legal guardian/person *in loco parentis* has provided written consent for the minor child to receive the COVID-19 vaccination.

_____ _____
Signature of Trusted Party Printed Name

Staff Use Only

Type of ID: _____

ID Number:_____

ID Verified By: _____

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COVID-19 Immunization Screening and Consent Form

Last Name (please print):		First Name:	Middle Initial:
Date of Birth:	Age:	Sex (Mark one): □ Male □ Female □ Other	
Address:		City:	State: Zip:
Parent/Guardian/ Surrogate (if applicable, please print):		Preferred Language:	
Phone Number:		Race (Mark one): □ AIA – Native American or Alaskan □ ASN – Asian □ BAA – African American or Black □ WHT – White □ NHP – Native Hawaiian or Pacific Islander □ DECL – Declined □OTH – Other or Multiracial	
Ethnicity (Mark one): □ DECL – Declined □ NHL – Non-Hispanic Origin □ HIS – Hispanic Origin □ UNK – Unknown			

Screening Questionnaire			
1.	Are you feeling sick today?	○ Yes	○ No
2.	Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product and the date administered? □ Pfizer □ Moderna □ Johnson & Johnson □ Another product	○ Yes Date:	○ No
3.	Have you ever had a severe allergic reaction to something, or a reaction that you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital? What is the allergy?:_____	○ Yes	○ No
4.	Have you received another vaccine in the last 14 days?	○ Yes	○ No
5.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90-days?	○ Yes	○ No
6.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	○ Yes	○ No
7.	Do you have a bleeding disorder or are you taking a blood thinner?	○ Yes	○ No
8.	Are you pregnant or breastfeeding?	○ Yes	○ No

Consent

I have read and understand or had explained to me the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction or ensured that the person receiving the vaccine 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 request that the COVID-19 vaccination to be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Guardian Signature:_____ Date: _____

For Administrative Use Only							
Vaccine	Dose	Route	Date/Time Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	___ml □ 1st ___ml □ 2nd	IM – L Arm IM – R Arm					