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 and Influenza 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 any COVID-19 Vaccine and/or influenza vaccine to the minor patient,_______________________________, who is between the ages of 5 and 17, to receive the COVID-19 and/or influenza vaccine in the attached *COVID-19 and Influenza Immunization Screening and Consent Form.*

I understand that COVID-19 vaccines have been granted Emergency Use Authorization or FDA-Approval by the U.S. Food and Drug Administration ("FDA"). I have been provided access to and read the Vaccine Information Fact Sheet for Recipients and Caregivers ("Fact Sheet"). (Read the Fact Sheets at https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.)

I understand the known and potential risks and benefits of the COVID-19 Vaccines and/or influenza 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 and Influenza 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 and/or influenza vaccine. The parent/legal guardian/person *in loco parentis* has provided written consent for the minor child to receive the COVID-19 vaccination and/or influenza vaccine.

____ ____
Signature of Trusted Party Printed Name

Staff Use Only

Type of ID: ________________________________

ID Number:________________________________

ID Verified By: _____________________________

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COVID-19 and Influenza Immunization Screening and Consent Form

Last Name (please print):	First Name:	Middle Initial:
Date of Birth:	Sex (Mark one): Male Female Other	Phone Number:
Address:	City:	State: Zip:
Parent/Guardian/Surrogate (if applicable, please print):	Preferred Language:	
Ethnicity (Mark one): DECL – Declined NHL – Non-Hispanic Origin HIS – Hispanic Origin UNK – Unknown	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	

COVID-19 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: _____________ Date: _________ Date: _________ Date: _________ Date: _________ Date: _________ Date: _________	○ Yes	○ 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 passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90-days?	○ Yes	○ No
5.	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
6.	Do you have a bleeding disorder or are you taking a blood thinner?	○ Yes	○ No
7.	Are you pregnant or breastfeeding?	○ Yes	○ No

Influenza Screening Questionnaire			
1.	Are you feeling sick today?	○ Yes	○ No
2.	Are you allergic to eggs or to any other components of the vaccine?	○ Yes	○ No
3.	Have you ever had a severe allergic reaction to the influenza vaccine in the past?	○ Yes	○ No
4.	Have you ever had Guillain-Barré Syndrome?	○ Yes	○ No

Consent

I have read or had explained to me the information sheet about the COVID-19 vaccination and/or the Influenza vaccination. I understand that if my COVID-19 vaccine requires two doses, I will need to be given two doses of this vaccine in order for it to be effective. If I have been fully vaccinated, it may be recommended that I take the COVID-19 booster. I understand that the COVID-19 and Influenza vaccinations may be administered at the same time. I have had a chance to ask questions which were answered to my satisfaction or ensured that the person receiving the vaccine(s) 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 vaccinations as described. I request that the COVID-19 and/or the Influenza vaccination 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 the vaccine(s) for which I am providing consent. 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: ______________________

Provider Note: If multiple vaccines are administered at a single visit (e.g., COVID-19 and influenza), administer each injection in a different injection site. For adolescents and adults, the deltoid muscle can be used for more than one intramuscular injection administered at different sites in the muscle.

Qualifying Medical Conditions: Cancer, chronic kidney diseases, chronic lung diseases, dementia or other neurological conditions, diabetes (type 1 or 2), Down syndrome, heart conditions, HIV infection, immunocompromised state, liver disease, overweight and obesity, pregnancy, sickle cell disease or thalassemia, smoking (current or former), solid organ or blood stem cell transplant, stroke or cerebrovascular disease, substance use disorder

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 ___ ml 3rd ___ ml	IM – L Arm IM – R Arm					
Influenza	___ ml	IM – L Arm IM – R Arm					