☐ COVID-19 Vaccine # 1 ☐ COVID-19 Vaccine # 2

I hereby request that I be immunized with the vaccine(s) listed above and hereby authorize the physicians, nurse practitioners, pharmacists and/or nurses of Children's Hospital of The King's Daughters Health System who are licensed to administer vaccines to immunize me with such vaccine(s). I understand that there is no guarantee that complete immunity will result from this/these immunization(s). I have been given a copy and have read, or have had explained to me, the information in the current Emergency Use Authorization for the vaccine I am receiving. I understand the benefits and risks of the vaccine. I have had a chance to ask questions, and any questions were answered to my satisfaction. I have truthfully answered all questions below.

I understand that the possibility exists for health care workers to become directly exposed to an individual's blood or body fluids in the administration of a vaccine. Virginia law authorizes health care providers to test individuals for HIV antibodies when the health care provider is exposed to the body fluids of an individual on the basis of deemed consent. In the event of exposure, I understand that I will be deemed to have consented to testing, and consent to release test results to the health care worker who may have been exposed. Prior to testing, I will be informed and given an opportunity to ask questions.

Screening Questions ***Please answer ALL***	YES	NO
1. Are you pregnant or breastfeeding?		
2. Do you have any serious allergies? Please list: ____		
3. Have you ever had an anaphylactic reaction to a previous vaccine or injectable medication?		
4. Do you have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
5. In the past two weeks have you tested positive for COVID-19 or are you currently on quarantine for COVID-19?		
6. In the past two weeks have you had exposure with anyone who has tested positive for COVID-19?		
7. Have you had new onset of fever, chills, cough, difficulty breathing, new onset of lack of smell or taste, sore throat, GI symptoms, severe fatigue and or headache?		

All vaccines are reported to the Virginia Department of Health VIIS electronic immunization database

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print clearly)

Last Name First Name Mi Birthdate Gender Male/female/other

Address of residency City State Zipcode Race/Ethnicity

Signature of person to receive vaccine/legal guardian **Date** **Time**

Date/Time	Vaccine	Dose #	Lot #	Expiry	EUA Date	EUA date given	Man.	Route/Site	Administrator Signature/Title
	COVID-19	1					PFIZER ☐ Moderna ☐	IM L Deltoid R Deltoid	
	COVID-19	2					PFIZER ☐ Moderna ☐	IM L Deltoid R Deltoid	