HAMILTON COUNTY PUBLIC HEALTH

PREVENT. PROMOTE. PROTECT.

Attestation For Administration of COVID-19 Vaccine to Minors *(Please PRINT Clearly)*

MINOR Legal Name: _____

MINOR Date of Birth: _____/_____/_____
MM DD YYYY

MINOR Ethnicity (Check One):
☐ Not Hispanic or Latino
☐ Hispanic or Latino

MINOR Gender Identity (Check One):
☐ Male
☐ Female
☐ Self Describe: _____

MINOR Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Native Hawaiian or Other Pacific Islander

Parent/ Guardian Information:

Legal Name: _____

Relationship to Minor: _____

Date of Birth: _____/_____/_____
MM DD YYYY

Phone Number: _____

Email Address: _____

Address: _____
Street Address

_____
City, State, Zip Code

I understand that the minor above is receiving a COVID-19 vaccine pursuant to a U.S. Food and Drug Administration (FDA) or Emergency Use Authorization (EUA) for minors aged 6 months and older. I have received and read the EUA/FDA Fact Sheet or Vaccine information sheet for recipients of this vaccine (and/or other vaccine documentation provided to me), which fully explains to me the risks and benefits of receiving this vaccine. I agree that Hamilton County Public Health (HCPH) has not made any guarantees to me or the minor above about the result(s) of this vaccination, and I understand that the minor above may experience side effect(s) after receiving this vaccine. If required depending on the vaccine manufacturer; I further understand that if this vaccine needs to be administered as a 2-dose series, I agree that I will adhere to the guidance and the above minor will receive the second dose within the recommended time frame.

I agree that it is my personal decision to have the minor above receive the EUA/FDA COVID-19 vaccine for minors aged 6 months and older, and I give HCPH permission to administer this vaccine to the minor above. By signing below, I further confirm that ; I am at least 18 years of age; I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by HCPH have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the parent or legal guardian of the minor listed above; and that I have signed this Attestation voluntarily.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Please complete the questionnaire on the back of this form.

FOR OFFICE USE ONLY Vaccine Administration

Vaccination Site: _____

Vaccine Manufacturer: ☐ Pfizer-BioNTech ☐ Moderna ☐ Jansen (J&J) ☐ Other: _____

Route/Site: ☐ IM - Left Deltoid ☐ IM - Right Deltoid ☐ Other: _____

Vaccine Documents provided by HCPH:
☐ EUA/FDA Fact Sheet for Recipient
☐ Vaccination Record Card

DOSE # ____ Administered by (PRINT FULL NAME): _____
Administrator Signature: _____
Date/Time Administered Dose: _____
Lot #: _____ Expiration Date: _____

DOSE # ____ Administered by (PRINT FULL NAME): _____
Administrator Signature: _____
Date/Time Administered Dose: _____
Lot #: _____ Expiration Date: _____

DOSE # ____ Administered by (PRINT FULL NAME): _____
Administrator Signature: _____
Date/Time Administered Dose: _____
Lot #: _____ Expiration Date: _____

DOSE # ____ Administered by (PRINT FULL NAME): _____
Administrator Signature: _____
Date/Time Administered Dose: _____
Lot #: _____ Expiration Date: _____

Last Edited: 7 June 2022

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. How old are you? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists