Child and Teen Medical Center, P.A. (CTMC)
Phone: 763-333-7733 Fax: 763-333-7711

Blaine:
11107 Ulysses St NE
Blaine, MN 55434

Fridley:
500 Osborne Rd NE, Suite 215
Fridley, MN 55432

Child & Teen Medical Center
Love...Kindness..Excellence

Pod:_____ Arrival:_____ Initials:_____

Patient Label

Dose # 1 / Dose # 2

COVID-19 VACCINE SCREENING AND AGREEMENT

Health History

Please talk to you HCP if you answer YES to any of the following:

Yes	No	Unknown	Question
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) to a previous dose of mRNA COVID-19 vaccine or any of its ingredients?
Yes	No	Unknown	Immediate allergic reaction of any severity within 4 hours to a previous mRNA COVID-19 vaccine dose or any of its ingredients (including polyethylene glycol [PEG])?
Yes	No	Unknown	Immediate allergic reaction of any severity to polysorbate?
Yes	No	Unknown	History of any immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle, vein, or subcutaneous or therapies not related to a mRNA COVID-19 vaccine ingredient or polysorbate)?
Yes	No	Unknown	Are you ill today with any of the following symptoms: ***fever, cough, loss of taste or smell, chills, body aches, runny nose, congestion, headache, vomiting or diarrhea?***
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No		Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product and date received:
Yes	No	Unknown	Have you received any other vaccines within the last 14 days?
Yes	No	Not applicable	Are you pregnant or any chance of pregnancy?

Agreement:

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact sheet for the following COVID-19 vaccines: Pfizer
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above
- Child and Teen Medical Center is acting solely as a vaccine administrator and is not responsible for any adverse effects of the COVID-19 vaccine.

Signature of patient or parent/guardian: _____

Printed Name:_____ Today's Date:___ _____