



CHECK LIST: Parent/Legal Guardianship Consent Form for Unaccompanied 16-17yr old This form may be used if the parent/legal guardian is unable to accompany their 16-17yr old child(ren) to Missoula City-County Health Department for Immunization Clinic Services.

Parent/legal guardian must:

- Complete and sign both pages of *Parent/Legal Guardianship Consent Form for Unaccompanied 16yr-17 yr old*
- Include a copy of a valid photo ID of the Parent/Legal Guardian completing the forms
- Complete registration form
- Complete pre-vaccination checklist
- Include a copy of your adolescent's insurance card (front and back)
- Send all of the above information with you adolescent to their visit
- Review the Emergency Use Authorization information for the Covid-19 Pfizer vaccine

Insurance subscriber's name _____

Subscriber's date of birth ____/____/____

Subscriber's address _____

If you have questions, please call (406) 258-4636



Parent/Legal Guardianship Consent Form for Unaccompanied 16yr-17yr Old

Please review the following information and authorization for COVID-19 Pfizer vaccination when you cannot be present at the time of COVID-19 vaccination. Sign if you wish to authorize Missoula City-County Health Department (MCCHD) to provide this designated service to your child/dependent.

I (we) have the legal right to preauthorize this facility to deliver the COVID-19 Pfizer Vaccine to my (our) child/dependent for the services provided by MCCHD. I (we) request and authorize MCCHD and its personnel to deliver the following services to my (our) child/dependent listed below. I (we) understand that I (we) will be notified by telephone (at the contact number listed below) in the event of an adverse reaction after receiving services (i.e. fainting). I (we) understand that upon receiving a COVID-19 Pfizer vaccine, my (our) child/dependent must wait at the clinic for 15-30 minutes for observation.

Please select all services requested:

[] COVID-19 Pfizer Vaccine Dose #1: _____ Dose #2: _____ Booster or Dose #3: _____

Client information:

_____/_____/_____
Last name First name MI Date of Birth

Parent/Legal Guardian Information:

_____/_____/_____
Last name First name MI Date of Birth

_____/_____/_____
Last name First name MI Date of Birth

Relationship to client (select one): [] Mother [] Father [] Other*: _____

[] Legal Guardian/Authorized Representative* (*documentation must be provided) Contact information for

Parent/Guardian: phone #:

Alternate phone #:

Parental/Legal Guardian Consent for MCCHD Outpatient Immunization Clinic Services

I give permission for my child/dependent to be seen by nursing staff at MCCHD as indicated above. I understand that MCCHD will inform me of any emergency regarding my child/dependent by phoning my contact telephone listed above.

X _____
Signature of Parent/Legal Guardian DATE

Release of Information:

I give permission for MCCHD Outpatient Immunization Clinic to request and/or share my child's/dependent's immunization record as needed for continuity of care with other medical providers, schools, and/or day care.

X _____
Signature of Parent/Legal Guardian DATE

You must attach a copy of your photo ID (driver's license, passport etc). Authorization expires 30 days from the date of signature*. *If signing for two consecutive vaccine doses within 30 days, screening and registration paperwork must be completed for both dates of service on the date of the vaccine.

Date _____ Apt Time _____



M Pf Jn

Patient Name _____
Last First Middle Initial

1 2 3 B K

Date of Birth ____ / ____ / ____ Sex M F

IN _____

Ethnicity

- Hispanic/Latino
- Not Hispanic/Latino
- Decline

Race

- White
- Native Hawaiian/Pacific Islander
- Asian
- Black/African-American
- American Indian or Alaska Native
- Other

Mailing Address _____

Phone _____

City _____ State _____ Zip _____

Mobile _____

Email _____

SMS Reminder

Acknowledgement and Consent: Please check the boxes to the right of each item.

1. **Consent to Treat:** I authorize Missoula City-County Health Department to administer treatment as deemed necessary for care of the patient named above. If applicable, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.
2. **Assignment of Benefits:** I authorize payment of medical benefits to Missoula City-County Health Department for services rendered.
3. **Privacy Notice:** I have reviewed a copy of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I may request a copy of the Notice of Privacy Practices for my own records.
4. **Declaration of Truth:** All of the information I have provided is accurate and true.

I authorize my healthcare provider and local public health agency to collect and enter immunization records into the Department of Public Health and Human Services "imMTrax" registry, a confidential computer system which contains immunization records. I understand information in the registry may be released to local health departments, as well as health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to my child's child-care facilities and schools to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

ACCEPT imMTrax State Immunization Registry

DECLINE imMTrax State Immunization Registry

Safety Acknowledgement and Waiver

EUA/COVID-19 Fact Sheet: I have read or have had explained to me the information contained in the Fact Sheet about the disease and the vaccine.

Authorization: I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine to be administered today to me or to the person named above for whom I am authorized to make this request

I understand that I must wait the full 15-30 minutes depending on my risk factors. This is a safety precaution to avoid possible problems associated with fainting or an allergic reaction.

Client (Parent/Guardian) Signature: _____ Date: _____

Guardian or Emergency Contact _____ Phone _____

Office Use Only

Dose: 1: ____ 2: ____ 3: ____ B: ____
Manufacturer/Lot # _____

No contraindications or precautions to vaccinations

Loc: L-Deltoid R-Deltoid _____ Start time _____ Finish Time _____

Reviewed by/Vaccinator Signature: _____ Date: _____

Prevaccination Checklist for COVID-19 Vaccination



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.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever received a dose of COVID-19 vaccine? <ul style="list-style-type: none"> If yes, which vaccine product(s) did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> Another Product (Johnson & Johnson) _____ How many doses of COVID-19 vaccine have you received? _____ Did you bring your vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? <i>(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an allergic reaction to: <i>(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.)</i> <ul style="list-style-type: none"> A component of a COVID-19 vaccine, including either of the following: <ul style="list-style-type: none"> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had an allergic reaction to another vaccine <i>(other than COVID-19 vaccine)</i> or an injectable medication? <i>(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.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Check all that apply to you:			
<input type="checkbox"/> Am a female between ages 18 and 49 years old			
<input type="checkbox"/> Am a male between ages 12 and 29 years old			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection			
<input type="checkbox"/> Have a bleeding disorder			
<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Am currently pregnant or breastfeeding			
<input type="checkbox"/> Have received dermal fillers			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			

Form reviewed by _____

Date _____

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