KAUAI VETERANS MEMORIAL HOSPITAL
4643 Waimea Canyon Dr, Waimea, HI 96796
(808) 338-9431

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA`I REGION

SAMUEL MAHELONA MEMORIAL HOSPITAL
4800 Kawaihau Rd, Kapa'a, HI 96746
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# KVMH Pediatric (5 - 11 year olds) Intake Consent Form
# Pfizer – BioNTech COVID Vaccination

**Child's Information:**

◯F ◯M

Last Name | First Name | Middle Name | Date of Birth | Gender

Phone Number | Parent / Guardian's Email

*Street Address* | *City* | *State* | *Zip Code*

*Insurance Provider* | *Group Number* | *Policy Number*

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic or Non-Latino

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

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| **COVID -19 Screening Questions** | **YES** | **NO** | **DON'T KNOW** |
|---|---|---|---|
| 1. Is your child sick today? | ◯ | ◯ | ◯ |
| 2. Has your child had a serious reaction to a vaccine in the past? | ◯ | ◯ | ◯ |

**Information on risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine (Pfizer Vaccine).**

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer Vaccine to prevent COVID-19 in individuals 12 years of age and older. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's **Fact Sheet for Recipients and Caregivers**.

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**Consent**

I have reviewed the information on risks and benefits of the Pfizer Vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named above to the vaccination appointment and, by giving my consent below; the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.

**I GIVE CONSENT** for the child named on this form to be vaccinated with the Pediatric Dose of the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Last Name First Name Relationship to Child

Signature Date

Address if different from child's Phone Number if different from child's

**To be filled out by the Immunizer:** *Patient Temperature:* _____ *Date:* _____

*Vaccination Time:*_____ ❑ *L Arm* ❑ *R Arm* *Lot #* _____ *RN Initials:*_____

**If patient's bodily temperature is 100º F or greater, please inform them that they should not receive the vaccine at this time. Instruct them to contact their primary care provider for next steps.**