Golden Gate Pediatrics **PATIENT** COVID / Flu Shot Waiver

Patient''s Name: _____ Patient's Date of Birth:_____

Select one or both. I would like to receive / my child to receive the:

❑ COVID vaccine ❑ Influenza vaccine

The purpose of this notice is to help you make an informed choice about whether you or your child want to and should receive this vaccine. By signing below you acknowledge and understand the benefits and risks of the vaccination as described in the Vaccine Information Sheets.

I request and consent that the vaccination be given to me or my child.

Responsible Party Name: _____

Responsible Party Signature: _____

Today's Date: _____

Screening Checklist for Contraindications to COVID and/or Influenza Vaccines

The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Y	N	Unknown
1. Is the patient sick today?			
2. Does the patient have allergies to medicine, food, a vaccine component, or latex?			
3. Has the patient had a serious reaction to a vaccine in the past, including feeling dizzy or fainting before, during, or after a shot?			
4. Has the patient, a sibling, or a parent had a seizure; has the patient had a brain or other nervous system problem, or Guillain-Barre?			
5. Has the patient ever been diagnosed with a heart condition (myocarditis or pericarditis) or has the patient had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
6. Has the patient ever felt dizzy or faint before, during, or after a shot?			
7. Is the patient anxious about getting a shot today?			

STAFF ONLY:
Form reviewed & vaccines administered by: _____ Date: _____