COVID-19 Vaccine

Age 5-11 Dose Administration Tool

CLIENT INFO

LAST NAME		FIRST & MIDDLE NAMES
DOB YYYY/MM/DD	AGE	HEALTH CARD NUMBER
SCHOOL		EMAIL ADDRESS

FOR CLINIC USE ONLY

PREVIOUS VACCINE

PREVIOUS VACCINE NAME	# DAYS SINCE LAST DOSE	TODAY'S DOSE #

PRE-SCREENING QUESTIONS

Question		
1. Acute Illness / Previous COVID infection within 6 months	YES	NO
2. Allergic reaction to: a. Any previous vaccines (COVID or routine) b. Injectable medications c. PEG, tromethamine and/or polysorbate allergies	YES	NO
3. Any previous history of: a. Myocarditis or pericarditis b. Multisystem Inflammatory Syndrome in Children (MIS-C)	YES	NO
4. Weakened immune system/Immunosuppressant medications or treatments	YES	NO
5. Bleeding disorder / Blood thinning medications	YES	NO
6. History of fainting / Needle fear	YES	NO

COMMENTS	PREVIOUS AEFI

DOSE ADMINISTERED:

MONOVALENT MODERNA XBB.1.5

Lot #: ________________ Dose: 25 mcg

Route: IM Dose #: **1 2 Booster**

Site: **Left** OR **Right** Deltoid

Date Given: __________________Time:____________

Given By: _________________________________

MONOVALENT PEDIATRIC PFIZER XBB.1.5

Lot #: ________________ Dose: 10 mcg

Route: IM Dose #: **1 2 Booster**

Site: **Left** OR **Right** Deltoid

Date Given: __________________Time:____________

Given By: _________________________________

☐ **Verbal Consent Obtained from Parent, Legal Guardian, or Substitute Decision Maker**

____ **(FIRST AND LAST NAME OF LEGAL GUARDIAN**

____ **(RELATIONSHIP TO CLIENT)**

☐ **Dose Administered in COVax**