Fill Out Your Child's Forms: Step by Step

Please fill out all the pages of your child's forms. Make sure the forms are complete and accurate. This guide helps answer your questions.

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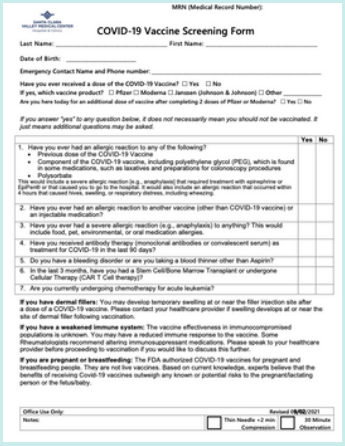
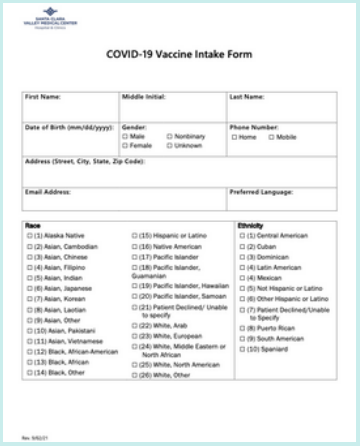

COVID-19 Vaccine Screening Form


COUNTY OF SANTA CLARA Health System

CONSENT TO COVID-19 VACCINATION


COVID-19 Vaccine Intake Form


Data Collection for COVID-19 Vaccine Equity

1. Write in your child's last name and first name. Use the spelling and names that match your legal documents. If your child has multiple last names, please include all of them. This will help us find your records in the future.

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Last Name: _____ First Name: _____

Date of Birth: _____

Emergency Contact Name and Phone number: _____

2. If your child received a COVID-19 vaccine in another country, please check "yes."

Page 1

Have you ever received a dose of the COVID-19 Vaccine? ☐ Yes ☐ No

If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other _____

Are you here today for an additional dose of vaccine after completing 2 doses of Pfizer or Moderna? ☐ Yes ☐ No

Santa Clara County PUBLIC HEALTH

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3. For most of these questions, your child should still be vaccinated if you answer "yes." If you answer "yes," the nurse will ask additional questions at the clinic.

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	Yes	No
1. Have you ever had an allergic reaction to any of the following? • Previous dose of the COVID-19 Vaccine • Component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.		
2. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?		
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to anything? This would include food, pet, environmental, or oral medication allergies.		
4. Have you received antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the last 90 days?		
5. Do you have a bleeding disorder or are you taking a blood thinner other than Aspirin?		
6. In the last 3 months, have you had a Stem Cell/Bone Marrow Transplant or undergone Cellular Therapy (CAR T Cell therapy)?		
7. Are you currently undergoing chemotherapy for acute leukemia?		

Have you ever had an allergic reaction to any of the following?

- ***Previous dose of the COVID-19 vaccine***
- ***Component of the COVID-19 vaccine, including polysorbate or polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures***

These allergic reactions are very rare. This does not include allergic reactions to food, pets, bee sting, or other vaccines, This question only asks if your child has ever had an allergic reaction to parts of the COVID-19 vaccine.

Answer "yes" if your child had a severe allergic reaction (such as anaphylaxis) to a part of the COVID-19 vaccine. This includes hives, swelling, or trouble breathing, including wheezing within 4 hours.

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Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or another injectable medication?

If you answer "yes," your child can still get vaccinated. A history of allergic reaction within 4 hours to any other vaccine will alert the clinic staff to be more cautious. Your child will need to wait for 30 minutes after vaccination in the rare case that an allergic reaction occurs.

Have you ever had a severe allergic reaction (anaphylaxis) to anything? This would include food, pet, environmental, or oral medication allergies.

If you answer "yes," your child can still get vaccinated. A severe allergic reaction means your child had trouble breathing, needed an EpiPen, or went to the hospital because of the allergic reaction. You do not need to mark "yes" if your child gets watery eyes or a stuffy nose when they are near foods, animals, or pollen.

Have you received antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 in the last 90 days?

If your child was sick with COVID-19 and they received monoclonal antibody treatment, wait 90 days before getting your child vaccinated.

Do you have a bleeding disorder or are you taking a blood thinner other than Aspirin?

If your child has a bleeding disorder or takes blood thinner, they can still get the vaccine. If this applies, the vaccinator will use a thinner needle. This special needle is only needed if your child has a bleeding disorder or is taking a blood thinner. Your child should not stop taking Aspirin or any anticoagulant before vaccination.

In the last 3 months, have you had a Stem Cell/Bone Marrow transplant or undergone Cellular Therapy (CAR T Cell therapy)?

Patients who have had T cell therapy or gotten a stem cell or bone marrow transplant may be immunocompromised. This makes them more likely to get COVID-19. It is highly recommended for those patients to get the vaccine. Talk to your child's doctor about a third dose if this applies.

Are you currently undergoing chemotherapy for acute leukemia?

Like patients who have had T cell therapy, children with leukemia who are actively getting chemotherapy have weaker immune systems, and are more at risk to contract COVID-19 virus. It is highly recommended that these children get vaccinated. Talk to your child's doctor about a third dose if this applies.

Fill Out Your Child's Forms: Step by Step

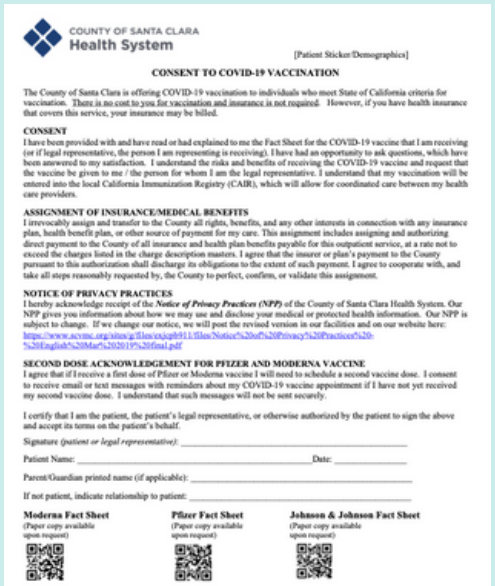
4. The consent form says that you understand your child will be receiving the COVID-19 vaccine and that a digital record of their vaccine will be entered into the California Immunization Registry (CAIR). If this is your child's first dose, it also says that you understand that your child will need to come back for a second dose in order to be fully immunized. QR codes at the bottom of the page connect you to more about the vaccines online.

Moderna Fact Sheet
(Paper copy available upon request)

Pfizer Fact Sheet
(Paper copy available upon request)

Johnson & Johnson Fact Sheet
(Paper copy available upon request)

Page 2



COUNTY OF SANTA CLARA
Health System

[Patient Sticker/Demographics]

CONSENT TO COVID-19 VACCINATION

The County of Santa Clara is offering COVID-19 vaccination to individuals who meet State of California criteria for vaccination. There is no cost to you for vaccination and insurance is not required. However, if you have health insurance that covers this service, your insurance may be billed.

CONSENT

I have been provided with and have read or had explained to me the Fact Sheet for the COVID-19 vaccine that I am receiving (or if legal representative, the person I am representing is receiving). I have had an opportunity to ask questions, which have been answered to my satisfaction. I understand the risks and benefits of receiving the COVID-19 vaccine and request that the vaccine be given to me / the person for whom I am the legal representative. I understand that my vaccination will be entered into the local California Immunization Registry (CAIR), which will allow for coordinated care between my health care providers.

ASSIGNMENT OF INSURANCE/MEDICAL BENEFITS

I irrevocably assign and transfer to the County all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment includes assigning and authorizing direct payment to the County of all insurance and health plan benefits payable for this outpatient service, at a rate not to exceed the charges listed in the charge description masters. I agree that the insurer or plan's payment to the County pursuant to this authorization shall discharge its obligations to the extent of such payment. I agree to cooperate with, and take all steps reasonably requested by, the County to perfect, confirm, or validate this assignment.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the ***Notice of Privacy Practices (NPP)*** of the County of Santa Clara Health System. Our NPP gives you information about how we may use and disclose your medical or protected health information. Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: https://www.scvmc.org/sites/g/files/exjcpb911/files/Notice%20of%20Privacy%20Practices%20-%20English%20Mar%202019%20final.pdf

SECOND DOSE ACKNOWLEDGEMENT FOR PFIZER AND MODERNA VACCINE

I agree that if I receive a first dose of Pfizer or Moderna vaccine I will need to schedule a second vaccine dose. I consent to receive email or text messages with reminders about my COVID-19 vaccine appointment if I have not yet received my second vaccine dose. I understand that such messages will not be sent securely.

I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature *(patient or legal representative)*: _____

Patient Name: _____ Date: _____

Parent/Guardian printed name (if applicable): _____

If not patient, indicate relationship to patient: _____

Moderna Fact Sheet (Paper copy available upon request)
Pfizer Fact Sheet (Paper copy available upon request)
Johnson & Johnson Fact Sheet (Paper copy available upon request)

5. A parent or guardian must sign to give consent for anyone under age 18. To allow your child to be vaccinated, sign the first line. Write your child's name on the second line and today's date. Then write out your full name in print on the third line, and your relationship to your child (for example, mother, uncle) on the bottom line.

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I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature *(patient or legal representative)*: _____

Patient Name: _____ Date: _____

Parent/Guardian printed name (if applicable): _____

If not patient, indicate relationship to patient: _____

6. Include all of your child's last names if they have more than one. Please write the date of birth in the format of Month/Day/Year. Include your phone number, address, and email address. Your contact information will be used to contact you about your child's second dose. Please also include your preferred language, so we can contact you in the language you prefer.

Page 3

First Name:	Middle Initial:	Last Name:
Date of Birth (mm/dd/yyyy):	Gender: ☐ Male ☐ Nonbinary ☐ Female ☐ Unknown	Phone Number: ☐ Home ☐ Mobile
Address (Street, City, State, Zip Code):		
Email Address:		Preferred Language:

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7. Race and ethnicity are collected to determine different populations' vaccine rates. You may check off more than one race. If you do not wish to answer, check "(21) Patient Declined". Please also select an ethnicity. If your child is not Hispanic or Latino, you may check "(5) Not Hispanic or Latino" for ethnicity.

Page 3

Race

- ☐ (1) Alaska Native
- ☐ (2) Asian, Cambodian
- ☐ (3) Asian, Chinese
- ☐ (4) Asian, Filipino
- ☐ (5) Asian, Indian
- ☐ (6) Asian, Japanese
- ☐ (7) Asian, Korean
- ☐ (8) Asian, Laotian
- ☐ (9) Asian, Other
- ☐ (10) Asian, Pakistani
- ☐ (11) Asian, Vietnamese
- ☐ (12) Black, African-American
- ☐ (13) Black, African
- ☐ (14) Black, Other
- ☐ (15) Hispanic or Latino
- ☐ (16) Native American
- ☐ (17) Pacific Islander
- ☐ (18) Pacific Islander, Guamanian
- ☐ (19) Pacific Islander, Hawaiian
- ☐ (20) Pacific Islander, Samoan
- ☐ (21) Patient Declined/ Unable to specify
- ☐ (22) White, Arab
- ☐ (23) White, European
- ☐ (24) White, Middle Eastern or North African
- ☐ (25) White, North American
- ☐ (26) White, Other

Ethnicity

- ☐ (1) Central American
- ☐ (2) Cuban
- ☐ (3) Dominican
- ☐ (4) Latin American
- ☐ (4) Mexican
- ☐ (5) Not Hispanic or Latino
- ☐ (6) Other Hispanic or Latino
- ☐ (7) Patient Declined/Unable to Specify
- ☐ (8) Puerto Rican
- ☐ (9) South American
- ☐ (10) Spaniard

8. The final set of questions is to help promote vaccine equity. Please answer all five questions, including the bolded question at the bottom. Answer the questions as they apply to your child, not as they apply to you. For example, if you are a migratory worker but your child is not, you would select "No." However, if you receive Section 8 Housing and your child lives with you, they are also receiving this housing and you would select "Yes." These questions are optional, so if you do not wish to answer them check "Declined to Answer" for all five questions.

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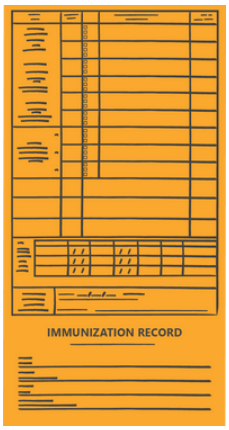
Data Collection for COVID-19 Vaccine Equity

Please check any of the items below if they apply to you:

I am a Migratory/Seasonal Agricultural Worker	☐ Yes ☐ No ☐ Declined to Answer
I am experiencing homelessness	☐ Yes ☐ No ☐ Declined to Answer
I receive Section 8 Housing subsidy	☐ Yes ☐ No ☐ Declined to Answer
I have limited ability to speak in English or read/write in English	☐ Yes ☐ No ☐ Declined to Answer

Do you have any type of disability including physical disability or mobility limitations, mental health disability, visual/hearing disability, intellectual or learning disability? ☐ Yes ☐ No ☐ Declined to Answer

The remaining questions on this page are these same five questions in different languages. You only need to answer the questions in your language.



Please check your forms to make sure all four pages are complete and accurate. This is especially important if you will not be going with your child when they get vaccinated. Bring the signed consent form and all completed forms. Also bring your child's yellow childhood immunization card if you have it.

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