City of CINCINNATI HEALTH DEPARTMENT

Attestation For Administration of COVID-19 Vaccine to Minors Per Emergency Use Authorization (Please PRINT Clearly)

Minor Full Legal Name: ________________________________

Minor Date of Birth ______/______/______
MM DD YYYY

Minor Race (Check One):
❑ White
❑ Black or African American
❑ Asian
❑ American Indian or Alaska Native
❑ Native Hawaiian or Other Pacific Islander

Minor Ethnicity (Check One):
❑ Hispanic or Latino
❑ Not Hispanic or Latino

Minor Sex (Check One): ❑ Male ❑ Female

Target Population or Occupation: ____________________________

Parent/Legal Guardian Contact Information:

Phone Number: (______-______-________)

Email Address: ________________________________

Address: ________________________________
Street Address

____
City, State, Zip Code

Vaccination Location: ________________________________

	Question	Yes	No
1.	Does the minor currently have an active infectious or acute respiratory illness, or fever?	❑ Yes	❑ No
2.	Has the minor ever had a severe allergic reaction to any of the vaccine ingredients listed in the EUA Fact Sheet or in other vaccine documents provided to you?	❑ Yes	❑ No
3.	Has the minor received another COVID-19 vaccine?	❑ Yes	❑ No
4.	Has the minor ever had a severe allergic reaction after a previous dose of this vaccine?	❑ Yes	❑ No
5.	Has the minor received any other vaccines within the past14 days?	❑ Yes	❑ No
6.	Is the minor pregnant or breastfeeding?	❑ Yes	❑ No
7.	Is the minor immunocompromised or are they on a medicine that affects their immune system? (Ex: cortisone, prednisone, anticancer drugs, rheumatoid arthritis medications Chron's disease or psoriasis, HIV/AIDS, leukemia, ankylosing spondylitis, or radiation treatment)	❑ Yes	❑ No
8.	Does the minor have a bleeding disorder or are they on a blood thinner?	❑ Yes	❑ No
9.	Does the minor have any allergies?	❑ Yes	❑ No

I understand that the COVID-19 vaccine the minor above is receiving is being administered to the minor above pursuant to a U.S. Food and Drug Administration Emergency Use Authorization (EUA). I have received and read the EUA Fact Sheet for recipients of this vaccine (and/or other vaccine documentation provided to me), which fully explains to me the risks and benefits of receiving this vaccine. I agree that City of Cincinnati Health Department (CHD) has not made any guarantees to me or the minor above about the result(s) of this vaccination, and I understand that the minor above may experience side effect(s) after receiving this vaccine. After the minor above receives the vaccine, we recommend the minor above wait on site at least 15 minutes. If the minor above leaves the vaccination site before 15 minutes has passed after the minor above's vaccination, I assume any risks associated with the minor above not waiting the recommended amount of time. Depending on the vaccine manufacturer, I further understand that if this vaccine needs to be administered as a 2-dose series, I agree that I will promptly schedule the minor aboves second-dose appointment as indicated.

I agree that it is my personal decision to have the minor above receive this EUA COVID-19 vaccine, and I give CHD permission to administer this vaccine to the minor above. By signing below, I further confirm that: the minor above is 12 years of age or older, I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by CHD have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the parent or legal guardian of the minor listed above and that I have signed this Attestation voluntarily.

Signature of patient or parent/legal guardian: ________________________________ Date: ____________________

Printed name of patient or parent/legal guardian: ________________________________