MOUNT NITTANY HEALTH

Pediatric COVID-19 Vaccination Additional Dose (3rd Dose) Agreement

Patient's Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

Please answer the following questions:

Today, does the patient have any of the following symptoms?

- Fever (temperature greater than 100.4ºF) ☐ Yes ☐ No
- Loss of taste and or smell ☐ Yes ☐ No
- Cough and or shortness of breath ☐ Yes ☐ No
- Nausea, vomiting, diarrhea ☐ Yes ☐ No
- Any other flu like symptoms ☐ Yes ☐ No

Has the patient ever had a serious reaction to a vaccination or medication in the past (anaphylaxis, swollen lips, tongue, throat, etc.) requiring medical treatment or emergency evaluation? ☐ Yes ☐ No

Has it been at least 28 days since the completion of the patient's initial mRNA COVID-19 vaccine series? ☐ Yes ☐ No

Attestation Acknowledgment and Signature:

- I attest and represent that the patient meets at least one of the currently applicable vaccination eligibility criteria as set forth by the PA Department of Health and/or CDC. The additional vaccine should be considered for people whose immune systems are compromised moderately to severely or who are receiving immunosuppressive medications or treatments such as:
  - Active treatment for solid tumor and hematologic malignancies
  - Receipt of a solid-organ transplant and taking immunosuppressive therapy
  - Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
  - Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
  - Advanced or untreated HIV infection
  - Active treatment with high-dose corticosteroids (≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory
- I understand that it is not possible to consider every possible side effect/complication to vaccination.
- I have had an opportunity to ask questions regarding the vaccination and my questions have been answered to my satisfaction.
- I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to my child or ward.
- I acknowledge that I have received the Notice of COVID-19 Immunization and Reporting Requirements and consent to informing the PA State Immunization Registry that my child or ward has received the COVID-19 vaccine.

Parent or Legal Guardian Printed Name: _____

Parent or Legal Guardian Signature: _____ Date: _____

Vaccinator Name (print): _____ Signature: _____ Date: _____

(Rev: 8/17/21)