BRANT COUNTY
HEALTH UNIT

194 Terrace Hill Street
Brantford, ON N3R 1G7
519-753-4937

www.bchu.org

PFIZER-BIONTECH COMIRNATY pediatric COVID-19 mRNA vaccine pre-screening assessment for children 5-11

Child's Name:	Child's Date of Birth:
Parent/Guardian Name:	Parent/Guardian Phone Number:

Has your child been sick in the past few days? Or had any recent shortness or breath or chest pain?	
NO ☐	YES ☐ Please explain: Recommendation to delay vaccination until illness fully resolved and consult with physician for any shortness of breath or chest pain prior to vaccination
Has your child had Covid-19 in the past 8 weeks?	
NO ☐	YES ☐ Please explain: Recommendation to delay Covid-19 vaccination for 8 weeks for symptom onset or + test if no symptoms
Has your child received another vaccine in the last 14 days?	
NO ☐	YES ☐ Please explain: Recommendation to space out COVID-19 vaccination 14d before and 14d after any other vaccination.
Has your child been diagnosed with myocarditis or pericarditis following an mRNA COVID-19 Vaccine?	
NO ☐	YES ☐ Please explain: Recommendation to delay Covid-19 vaccination
Has your child ever had myocarditis or pericarditis before?	
NO ☐	YES ☐ Please explain: Recommendation to consult clinical team for individual considerations and recommendations. If the diagnosis is remote and child no longer followed clinically for cardiac issues, they should receive the vaccine

Please note this pre-assessment form needs to be completed and submitted with the COVID-19 Vaccination consent form for your child to receive their vaccine at their school-based clinic.

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Does your child have a previous history of multisystem inflammatory syndrome in children (MIS-C)?	
NO ☐	YES ☐ Please explain: Recommendation to delay Covid-19 vaccination until clinical recovery has been achieved or until it has been ≥ 90 days since diagnosis, whichever is longer
Has your child had a serious allergic reaction or a reaction within 4 hrs to the COVID-19 vaccine before?	
NO ☐	YES ☐ Please explain: Consultation with your healthcare provider and allergist required prior to COVID-19 vaccination
Does your child have allergies to polyethylene glycol, tromethamine (or polysorbate?)	
NO ☐	YES ☐ Please explain: Consultation with your healthcare provider and allergist may be required prior to COVID-19 vaccination
Has your child had a serious allergic reaction to a vaccine or medication given by injection (e.g., IV, IM)?	
NO ☐	YES ☐ Please explain: Recommendation to wait in clinic 30min (instead of 15min) post immunization for observation
Does your child have a weakened immune system or are they taking any medications that can weaken the immune system (e.g., high dose steroids, chemotherapy)?	
NO ☐	YES ☐ Please explain: Appropriate timing of your child's COVID-19 vaccine should be reviewed with your child's treating provider
Does your child have a bleeding disorder or are they taking blood thinning medications?	
NO ☐	YES ☐ Please explain: Child is safe to receive COVID-19 vaccination
Has your child ever felt faint or fainted after receiving a vaccine or medical procedure?	
NO ☐	YES ☐ Please explain: Please ensure your child eats a good breakfast prior to the vaccination clinic.

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