June 21, 2021

DOH-BROWARD ADMINISTERING PFIZER COVID-19 VACCINE AT BROWARD COUNTY PUBLIC SCHOOLS

Contact:
Nina Levine
Public Information Office
Nina.Levine@FlHealth.gov

Fort Lauderdale, Fla – The Florida Department of Health in Broward County (DOH-Broward), in partnership with Broward County Public Schools (BCPS) and Broward County, is providing free, voluntary Pfizer COVID-19 vaccinations to students, staff and their families ages 12 and up during the summer session. Vaccinations will begin Tuesday, June 22 and will be administered at 35 Broward County public schools.

One school will act as a hub for each Broward County Public School Innovation Zone. Parents, students, and staff can attend the school vaccination event of their choosing, even if the child or staff member does not attend the specific school.

No insurance is required, and no appointment is necessary.

DOH-Broward will provide first doses to individuals not yet vaccinated and will return to each school 21 days later to administer second doses.

Students less than 18 years of age will need to bring a consent form signed by a parent or guardian with them to the event or be accompanied by a guardian. DOH-Broward will provide parents and guardians the opportunity to review the EUA Fact Sheet for Recipients and Caregivers and ask questions in advance.

The in-school vaccination schedule can be found below as well as the COVID-19 Vaccine Screening and Consent Form. The Pfizer Emergency Use Authorization Fact Sheet for Recipients and Caregivers can be found here.

About the Florida Department of Health

The Department works to protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.

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First Dose	Second Dose	School	Open	Close
22-Jun	13-July	Deerfield Beach Middle	7:00 A.M.	4:30 P.M.
22-Jun	13-July	Blanche Ely High	7:00 A.M.	4:30 P.M.
22-Jun	13-July	Coral Spring High	7:00 A.M.	4:30 P.M.
22-Jun	13-July	Monarch High	7:00 A.M.	4:30 P.M.
22-Jun	13-July	Coral Glades High	7:00 A.M.	4:30 P.M.
22-Jun	13-July	Bright Horizons	8:00 A.M.	5:00 P.M.
22-Jun	13-July	Crystal Lake Middle	9:00 A.M.	5:00 P.M.
22-Jun	13-July	Westglades Middle	9:00 A.M.	5:00 P.M.
23-Jun	14-July	Coconut Creek High	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Atlantic Technical College	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Millennium 6-12	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Bair Middle	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Boyd Anderson High	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Plantation High	7:00 A.M.	4:30 P.M.
23-Jun	14-July	Cross Creek	9:00 A.M.	5:00 P.M.
23-Jun	14-July	Dave Thomas Education Center	9:00 A.M.	5:00 P.M.
24-Jun	15-July	Dillard 6-12	7:00 A.M.	4:30 P.M.
24-Jun	15-July	Fort Lauderdale High	7:00 A.M.	4:30 P.M.
24-Jun	15-July	William Dandy Middle	9:00 A.M.	5:00 P.M.
24-Jun	15-July	Sunrise Middle	9:00 A.M.	5:00 P.M.
24-Jun	15-July	Indian Ridge Middle	9:00 A.M.	5:00 P.M.
24-Jun	15-July	Seminole Middle	9:00 A.M.	5:00 P.M.
28-Jun	19-July	Sheridan Technical College	7:00 A.M.	4:30 P.M.
28-Jun	19-July	Pioneer Middle	7:00 A.M.	4:30 P.M.
28-Jun	19-July	Falcon Cove Middle	7:00 A.M.	4:30 P.M.
28-Jun	19-July	Silver Trail Middle	7:00 A.M.	4:30 P.M.
28-Jun	19-July	Whidden Rogers Education Center	9:00 A.M.	5:00 P.M.
28-Jun	19-July	The Quest	9:00 A.M.	5:00 P.M.
29-Jun	20-July	New Renaissance Middle	7:00 A.M.	4:30 P.M.
29-Jun	20-July	McNicol Middle	7:00 A.M.	4:30 P.M.
29-Jun	20-July	Hollywood Hills High	7:00 A.M.	4:30 P.M.
29-Jun	20-July	South Broward High	7:00 A.M.	4:30 P.M.
29-Jun	20-July	Glades Middle	9:00 A.M.	5:00 P.M.
29-Jun	20-July	McArthur High	9:00 A.M.	5:00 P.M.
29-Jun	20-July	Whispering Pines	9:00 A.M.	5:00 P.M.

COVID-19 VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/Facility ID: ____________________________________

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Name: Last:	First:	Middle Initial:
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian): ( )**	
Address:	**Apt/Room #:**	
City:	**State:**	**Zip:**
Name of Legal Guardian: Last:	First:	Middle Initial:
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Other Nonwhite ☐ Black or African American ☐ White ☐ Other Pacific Islander	**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary Insurance Carrier ID #:______________________Grp #: ____________________
Insurance Company :____Insurance Company Phone #_____________________
Insured's Name:________________________________Relationship:_____________________Insured's Date of Birth___________
Secondary Insurance Carrier ID #:______________________Grp #: ____________________
Insurance Company :____Insurance Company Phone #_____________________
Insured's Name:________________________________Relationship:_______________________Insured's Date of Birth____________

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	**Yes**	**No**
1. Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
2. Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?		
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
4. Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)?		
5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, COVID Convalescent Plasma, etc.)		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or No for each question.	**Yes**	**No**
6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?		
7. For women, are you pregnant or is there a chance you could become pregnant?		
8. For women, are you currently breastfeeding?		
9. Are you immunocompromised or on a medication that affects your immune system?		
10. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
11. Are you a female age 18 to 49 years old receiving the Janssen (Johnson and Johnson) COVID-19 vaccine?		
12. If you are under the age of 18 are you and/or your guardian aware that you are only eligible to receive the Pfizer vaccine?		
13. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age (for Pfizer vaccine consent only); or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.

- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 12 years of age or older (Pfizer only) or 18 years of age and older (Pfizer, Moderna and Johnson and Johnson) ; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), the Florida Division of Emergency Management (FDEM) and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH, FDEM, or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH, FDEM, or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of Patient or Authorized Representative____________________________________ **Date:** ________________

Print Name of Representative and Relationship to Person Receiving Vaccine: ____

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at location: facility name/ID	
Administered at location: Type	
Administration Address:	
CVX (product)	
Sending organization:	

Vaccinator Print Name: ____________________________ **Signature:** ________________________ **Date:** __________

Vaccine administering provider suffix: ____________________________