Fresno Unified School District
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FOR IMMEDIATE RELEASE
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MEDIA ADVISORY

District to Open Free COVID-19 Vaccination/Testing Clinics at Six Schools

What: Fresno Unified launches vaccination/testing clinics

When: Monday, Sept. 20, 2021
10:30 a.m.

Where: McLane High School cafeteria – parking available in lot near stadium
2727 N. Cedar Ave. (93703)

The district will announce the opening of COVID-19 vaccination and testing clinics at McLane, Patiño and Roosevelt high schools and Scandinavian, Tehipite and Terronez middle schools, with plans for additional sites. The free clinics will provide a convenient way for students 12 and older to be vaccinated, as well as district staff.

Youth ages 12-17 must bring signed consent forms or be accompanied by their parent/guardian. Clinic partners are Immigrant Refugee Coalition, Pinnacle Training Systems, Fresno County Department of Public Health, UCSF COVID-19 Equity Project, Centro La Familia and African American Coalition.

Speakers will include Superintendent Bob Nelson, Valley Children's Hospital President/CEO Todd Suntrapak and Dr. Trinidad Solis from Fresno County Department of Public Health.

“I would encourage our Fresno Unified family to take advantage of our vaccination and testing sites. We know that more fully vaccinated students and staff make our campuses even safer,” said Superintendent Bob Nelson.

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Stay informed of Fresno Unified’s activities online:

Fresno Unified COVID-19 Vaccination Clinic

FREE vaccines for ages 12+
Pfizer and Johnson & Johnson vaccines will be available &
FREE walk-up COVID-19 testing

Location	1st Dose	2nd Dose	Time
McLane HS Cafeteria	9-20-21	10-11-21	10:00 a.m. to 3:00 p.m.
Scandinavian MS Cafeteria	9-20-21	10-11-21	4:00 p.m. to 8:00 p.m.
Patińo SOE Cafeteria	9-22-21	10-13-21	10:00 a.m. to 3:00 p.m.
Terronez MS Cafeteria	9-24-21	10-15-21	1:00 p.m. to 6:00 p.m.
Tehipite MS Parking Lot	9-30-21	10-21-21	3:00 p.m. to 8:00 p.m.
Roosevelt HS Cedar Lot	10-2-21	10-23-21	10:00 a.m. to 2:00 p.m.

Signed consent forms required for youth between 12 to 17 years of age. Parents do not need to be present if youth has signed consent forms with them.

For more information call (559) 258-1355
or register at: myturn.ca.gov

FUSD Consent Form
→ tinyurl.com/FUSDConsent

Pinnacle Consent Form
→ tinyurl.com/PinnacleConsent

Fresno County Department of Public Health
Pfizer-BioNTech COVID-19 Vaccine Consent
For Individuals Under 18 Years of Age

Section 1: Information about the child to receive Pfizer-BioNTech COVID-19 Vaccine (please print):

Child's Name (Last, First, Middle) Date of Birth (mm/dd/yyyy) Age

Street Address City State Zip

Phone Number

Section 2: Information on the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine (Pfizer Vaccine).

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the Pfizer Vaccine to prevent COVID-19 in individuals 12 years of age and older. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's Fact Sheet for Recipients and Caregivers.

Section 3: Parent/Guardian Consent.

I have reviewed the information on risks and benefits of the Pfizer Vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named above to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record web form.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Name (Last, First, Middle) Relationship to Minor

Signature Date

Address if different from above

Phone Number if different from above

PINNACLE TRAINING SYSTEMS, LLC
PEDIATRIC COVID-19 VACCINE SCREENING AND CONSENT FORM

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Name

Date of Birth			Age in Years:	Sex (Gender assigned at birth) ☐ Male ☐ Female
Month	Day	Year		

Race
☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other ☐Pacific Islander ☐White ☐Other Asian ☐Other Nonwhite ☐Other Pacific Islander ☐Other

Ethnicity
☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Address

City	State	Zip Code

Cell Phone Number — Email Address

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

SECTION 2: SCREENING

Please check YES or NO for each question.	YES	NO
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had, in the last 10 days, 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?		
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

SECTION 3: CONSENT

As the parent/legal guardian of the child named below, I hereby give my full consent and approval for my child to receive the COVID-19 vaccine. I hereby state that my child is twelve (12) years or older.

I understand that common reactions to vaccinations include:

- soreness around the injection site
- fever
- chills
- headache
- tiredness
- achy feeling.

I understand I should notify my child's doctor if soreness around the injection site lasts more than two (2) days.
I understand I should seek medical attention immediately if the following occurs:

- any allergic reactions such as rash, swelling of the tongue/lips
- shortness of breath

I understand and agree to remain with my child for 15mins observation after receiving the injection.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless PTS and the State of California, the California Department of Public Health (CDPH), 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 understand that a vaccine can possible cause serious problems such as severe allergic reactions, although the risk of a vaccine causing serious injury or death is extremely small. In consideration of my child receiving the COVID-19 vaccination I assume the risk of an accept full responsibility for any and all injuries including death. I know and understand the vaccine has been approved by the FDA for use in 16-year-old and up and has been approved for emergency use in 12 year to 15 year old's. I am requesting that Pinnacle give the vaccine to my child.

______________________________________	________________
Signature of Patient or Authorized Representative	**Date**

______________________________________	________________
Print Name	**Relationship to Person Receiving Vaccine**