CONSENT TO COVID-19 VACCINATION AND RELATED TREATMENT FOR MINOR

Minor Patient Name: _____

Minor Patient Date of Birth: _____/_____/_____

Minor Patient Address: _____

Name: _____

Relationship to Minor: _____

Phone Number: _____

I am the:

___ Parent of the minor patient

___ Legal guardian of the minor patient

___ Other person with authority to make healthcare decisions on behalf of the minor patient, describe legal

Relationship: _____

I hereby attest to the following:

• The minor patient is 5 years of age and up to 11 years of age.

• I have the legal authority to consent to the administration of the Pfizer-BioNTech COVID-19 Vaccine to the minor patient

• I understand that the U.S. Food and Drug Administration ("FDA") has authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine, which is not an FDA-approved vaccine.

• I have been provided access to and read the Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers

• I understand the known and potential risks and benefits of Pfizer-BioNTech COVID-19 Vaccine and the extent to which such risks and benefits are unknown.

• I understand that I have the option to accept or refuse Pfizer-BioNTech COVID-19 Vaccine on behalf of the minor patient.

• I understand that the Pfizer-BioNTech COVID-19 Vaccine is a two-part vaccine series.

• I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions.

• **The minor patient and I agree that the minor patient will remain in the observation area for the required time period following vaccine dose administration.**

• I consent to the administration of two separate doses of Pfizer-BioNTech COVID-19 Vaccine spaced approximately three weeks apart to the minor patient.

FIRST DOSE: _____

SECOND DOSE: _____

_____

Printed Name of Parent, Legal Guardian, or Other Authorized Individual Date

_____

Signature of Parent, Legal Guardian, or Other Authorized Individual Date

COVID-19 Vaccine Screening Questions for Minors

Minor Patient Name: _____

Minor Patient Date of Birth: _____/_____/_____

Minor Patient Address: _____

Screening Questions

1. Do you give consent to receive the COVID-19 vaccine today? YES NO

2. Are you feeling sick today? YES NO

3. Have you ever received a dose of the COVID-19 vaccine? YES NO

If yes, which vaccine did you receive and on what date?

Vaccine Name: _____ Date: _____

4. Are you immunocompromised/taking medications that affect your immune system? YES NO

If yes, please explain and list medications: _____

_____

5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to anything? YES NO

If yes, please explain: _____

_____

6. Have you received antibody therapy as treatment for COVID-19 in the past 90 days? YES NO