

**CONSENT TO COVID-19 VACCINATION AND RELATED TREATMENT FOR MINOR OR
INDIVIDUAL WITH A GUARDIAN**

Patient Name:	Patient Date of Birth:
Patient Address:	
Parent or Guardian Phone Number:	

I am the: Parent of the minor patient Legal guardian of the patient
 Other person with authority to make healthcare decisions for the patient, describe legal relationship:

I hereby attest to the following:

- The Patient is 12 years of age or older.
- I have the legal authority to agree to the administration of the Pfizer- BioNTech COVID-19 Vaccine (“Vaccine”) to the Minor Patient.
- I understand that the U.S. Food and Drug Administration (“FDA”) has authorized the emergency use of the Vaccine.
- I have been given access to and read the Vaccine Emergency Use Authorization (EUA) Fact Sheet.
 - For the EUA in English, [click here](#).
 - For the EUA in Spanish, [click here](#).
- I have been given a chance to ask questions about the virus, vaccine, and treatment. I understand the known and potential risks and benefits of the Vaccine and the extent to which such risks and benefits are unknown.
- I understand that I have the choice to accept or refuse the Vaccine for the Patient.
- I agree to give two doses of the Vaccine spaced about three weeks apart to the Patient.
- I understand that the Vaccine is a two-part vaccine series needing two shots and it will not be fully effective until after the second shot.
- I understand as with all vaccines, there is no guarantee that the Patient will become immune or that he/she will not have side effects.
- I understand that the Patient must stay for 15-30 minutes after the vaccination for patient safety.

Based on the above, I ask for the Vaccine to be given to the Minor Patient

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

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