Minor Pfizer-BioNTech COVID-19 Vaccination Consent

PATIENT INFORMATION: School Name: _____

Name Last: _____ First: _____

Date of Birth (M/D/Y): _____ Sex: M ___ F___ Transgender ___ Self-Identify _____

Address: _____ City: _____

State: ____ Zip: _____ PCP/Clinic Name: _____ PCP/Clinic Phone: _____

PARENT/GUARDIAN INFORMATION:

Name Last: _____ First: _____

Email: _____ Phone _____

EMERGENCY CONTACT:

Name Last: _____ First: _____

Relationship to Patient: _____ Phone _____

HEALTH HISTORY (For school vaccination events: If any answers to these questions change after the form is submitted, please contact the School Nurse.):

1. Is your child moderately or severely ill today? Yes_____ No_____
2. Does your child have allergies to food or medications? Yes_____ No_____
3. Has your child ever had a serious reaction after a vaccination or any injectable medication? Yes_____ No_____
4. In the past 14 days, has your child tested positive for COVID-19? Yes_____ No_____
5. In the past 14 days, has your child had contact with another person with lab confirmed COVID-19? Yes_____ No_____
6. Has your child received a monoclonal antibody or convalescent plasma for COVID-19 in the last 90 days? Yes_____ No_____
7. Has your child received a COVID-19 vaccine before? If yes, list date(s) Yes_____ No_____

_____ _____

☐ **For third doses only:** I request that a third COVID-19 vaccine dose be given to the person for whom I am authorized to make this request. This person is 12 years or older, has a qualifying condition as defined by the Centers for Disease Control and Prevention (CDC), and it has been at least 28 days from the last COVID-19 vaccine dose.

This form must be signed by parent or guardian to verify eligibility and signify consent to receive the indicated vaccine. I understand that this COVID-19 vaccine is approved by the FDA for ages 16 and older and is authorized for emergency use and not approved by the FDA for ages 5-15 or third doses. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to the person for whom I am authorized to make this request.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the Countermeasures Injury Compensation Program and filing a claim is available by calling 1-855-266-2427 or visiting http:/ / www.hrsa.gov/ cicpj.

Signature: _____ Date: _____