KAISER PERMANENTE®

Location: _____

MR #: _____

Name: _____

CONSENT FORM

IMPRINT AREA

CONSENT TO COVID-19 VACCINATION AND RELATED TREATMENT FOR MINOR PATIENTS

Parental consent is required for the vaccination of patients under the age of 18. Please bring this completed Consent Form and Screening Questionnaire to your first dose appointment.

Minor Patient Name: (First name Last name)	
Minor Patient Medical Record Number:	
Minor Patient Date of Birth: (Month, Day, Year)	
Emergency Contact Number:	

I am the: ☐ Parent of the minor patient ☐ Legal guardian of the minor patient

☐ Other person with the legal authority to make healthcare decisions on behalf of the minor patient:

_____

(*describe legal relationship*)

I hereby attest to the following:

- The minor patient is 12 years of age or older.
- 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 with access to and have read the Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers ("Fact Sheet"). (Read the Fact Sheet at fda.gov/media/144414/download or scan the QR code at the bottom of this Consent Form.)
- I have had an opportunity to ask questions regarding the Pfizer-BioNTech COVID-19 Vaccine and have been provided with answers.
- I understand the known and potential risks and benefits of the 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 the Pfizer-BioNTech COVID-19 Vaccine on the minor patient's behalf.
- I understand that the Pfizer-BioNTech COVID-19 Vaccine is a two-part vaccine series.
- I consent to and authorize the administration of the Pfizer-BioNTech COVID-19 Vaccine to the minor patient.
- 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.

_____

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

_____

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