PARENT/GUARDIAN/REPRESENTATIVE CONSENT FORM for COVID-19 VACCINE

FULL LEGAL NAME OF PATIENT: _____

PATIENT DATE OF BIRTH: _____

By signing below, I acknowledge the following and consent to the checked COVID-19 vaccine being given to the person named above for who I am authorized to make this request.

Moderna	**Pfizer**
6 months to 5 years	6 months to 4 years
6 years to 11 years	5 years to 11 years
12 years and older	12 years and older

I understand the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine; I know it is not a fully licensed FDA vaccine for this age group.

The patient was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.

I have been provided a copy of the EUA (Emergency Use Authorization) for the above selected vaccine and have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine.

PARENT/GUARDIAN/REPRESENTATIVE

FULL LEGAL NAME: _____

SIGNATURE: _____

Relationship to patient: _____

Phone Number: _____