COVID-19 vaccine Consent Form for Individuals 5-17 Years of Age

Section 1: Information about the child to receive Pfizer COVID-19 Vaccine (please print):

____ ____________ ____________
Child's Name (Last, First, MI) Date of birth (mm/dd/yyyy) Age

____
Street Address

____ ___________ _________
City State Zip Code

____
Phone Number

Section2: Patient Insurance Information:

PRIMARY INSURANCE_____

Policyholder___________________________

Policyholder date of birth________________

Social Security #________________________

Relationship to patient___________________

SECONDARY INSURANCE

Policyholder___________________________

Policyholder date of birth________________

Social Security #________________________

Relationship to patient___________________

Section 3: Information about the Pfizer Vaccine

Your child is being offered a COVID-19 vaccine made by Pfizer-BioNTech. The PfizerBioNTech COVID-19 Vaccine is approved by the U.S. Food and Drug Administration (FDA) for people over 16 years old, with the brand name Comirnaty. The FDA has also issued an Emergency Use Authorization for Pfizer-BioNTech COVID-19 Vaccine for people ages 5 and older. Both the Pfizer-BioNTech COVID-19 Vaccine and Comirnaty are administered as a 2-dose series, 3 weeks apart, into the muscle.

The vaccine provider will need certain information about your child's medical history before administering the vaccine. The vaccine may not protect everyone from COVID-19 disease. Some people may experience side effects after getting the vaccine. Side effects that have been reported include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine. For this reason, we recommend you wait at least 15 minutes after receiving your vaccine. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body.

Additional information is available in the Pfizer-BioNTech COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" available at:

- Recipients and Caregivers 5-11 years of age (fda.gov) https://www.fda.gov/media/153717/download
- Recipients and Caregivers 12 years of age and older (fda.gov) https://www.fda.gov/media/153716/download

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Section 4: Screening Questions

Please answer the health questions below:	Yes	No	Unknown
1. Have you ever had a severe allergic reaction to a vaccine or any injection in the past?			
2. Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?			
4. Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?			
5. Do you have any serious health conditions?			
6. Do you have a weakened immune system (i.e. from HIV or cancer) or are you on immunosuppressive drugs?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			
9. Do you feel sick today?			

Section 5: Consent

CONSENT FOR MINOR'S VACCINATION: I have reviewed the information about the PfizerBioNTech and Comirnaty COVID-19 Vaccines in Section 2 above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the Pfizer-BioNTech and Comirnaty COVID-19 Vaccines.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech or Comirnaty COVID-19 Vaccine.
3. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the Pfizer Comirnaty COVID-19 Vaccine. The government is paying for the Pfizer Comirnaty COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
5. I understand that as required by state law, all immunizations will be reported to the Ohio Department of Health, Immunization Information System.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech or Comirnaty COVID-19 Vaccine and have reviewed and agree to the information included in Section 3 of this form. (If this consent is not signed, dated, and returned, the child will not be vaccinated.)

Signature of Legally Authorized Representative   Date

Section 6: Vaccination Record
FOR OFFICE USE ONLY

Date	Manf.	Lot #	Exp.	Dose	Route	Site	Fact sheet given	Nurse Signature