COVID-19 VACCINATION PEDIATRIC CONSENT FORM

Pfizer-BioNTech COVID-19 Vaccine

PLEASE PRINT CLEARLY

Last name ______________________ First Name ______________________

Street ______________________ City ____________ State ______ Zip ______

Telephone Number ______________________ Date of Birth ____________ Gender ____________

Ethnicity: ◯ Hispanic ◯ Not Hispanic ◯ Unknown

Race: ◯ White ◯ Black or African American ◯ American Indian ◯ Asian ◯ Other

Parent or Legal Guardian Name: ______________________ Phone Number: ______________________

- I, as the parent or legal guardian, certify that the patient is 5-11 years of age, and I consent to the Grayson County Health Department to administer the COVID-19 vaccine.
- I, as the parent or legal guardian, understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 5-11 years of age; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I, as the parent or legal guardian, understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine. I have elected for the above mentioned child to receive the vaccine. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I, as the parent or legal guardian, acknowledge that I have been advised to have the child remain at the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, call 9-1-1 or go to the nearest hospital.
- I, as the parent or legal guardian, hereby release and hold harmless the Grayson County Health Department, and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I, as the parent or legal guardian, acknowledge that I understand the purposes/benefits of Texas's immunization registry and the above-mentioned child's personal immunization information will be shared with the Centers for Disease Control (CDC), local, state, and/or other federal agencies, or medical providers.
- I, as the parent or legal guardian, have received or reviewed the office's Notice of Privacy Practice, which explains how the above mentioned child's medical information will be used and disclosed, in addition to the acknowledgment directly above this statement. I understand that I am entitled to receive a copy of this document. THIS DOCUMENT IS AVAILABLE UPON REQUEST.

MEDICAL SCREENING QUESTIONS: Check yes or no to each question below.

Question	Yes	No
Does the child have any allergies?		
Is the child feeling sick today or have a fever?		
Does the child have a bleeding disorder or on a blood thinner?		
Is the child immunocompromised or is the child on a medication that affects their immune system?		
Does the child have myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?		
Is the child pregnant?		
Is the child breastfeeding?		
Has the child received another COVID-19 vaccine?		
If so, please name the manufacture		
Has the child ever fainted in association with an injection?		

I attest that the contents of this COVID-19 Vaccination Pediatric Consent Form are true and correct.

______________________________ ______________

Signature of Recipients Authorized Individual (parent or legal guardian) **Date**

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Print Name of Representative and Relationship to the person receiving the vaccine

DO NOT WRITE IN THIS SPACE – OFFICE USE ONLY

Manufacture: Pfizer-BioNTech
Administration Date: ____________________
Lot #: __________ Expiration Date: __________

Site (circle one): RIGHT LEFT

______________________________ ______________

Nurse/Provider's Signature Date