



**CONSENT TO COVID-19 VACCINATION AND RELATED TREATMENT FOR MINOR WITHOUT  
A PARENT/LEGAL REPRESENTATION**

Consent is required for vaccination of patients under the age of 18 without a parent/legal representative present.

<b>Minor Patient Name:</b>	<b>Minor Patient Date of Birth:</b>
<b>Minor Patient Address:</b>	
<b>Emergency Contact:</b> Name: _____  Relationship to Minor: _____  Phone Number: _____	

I am the:   \_\_\_ Parent of the minor patient                      \_\_\_ Legal guardian of the minor patient  
  
              \_\_\_ Other person with authority to make healthcare decisions on behalf of the minor patient, describe legal  
relationship: \_\_\_\_\_

I hereby attest to the following:

- The patient is a minor and eligible for the Pfizer-BioNTech COVID-19 Vaccine
- 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 access to and read the Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers ("Fact Sheet"). (Read the Fact Sheet at <https://www.fda.gov/media/144414/download> or scan the QR code at the bottom of this form).
- I understand the known and potential risks and benefits of 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 Pfizer-BioNTech COVID-19 Vaccine on behalf of the minor patient.
- I understand that the Pfizer-BioNTech COVID-19 Vaccine is a two-part vaccine series.
- 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.
- I consent to the administration the Pfizer-BioNTech COVID-19 Vaccine.

\_\_\_\_\_  
Printed Name of Parent, Legal Guardian, or Other Authorized Individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian, or Other Authorized Individual

\_\_\_\_\_  
Date

