



St. Croix Regional Family Health Center

COVID-19 Minor Vaccine CONSENT Form - Pfizer

Child's Name: (Print) _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone #: _____ Primary Care Provider: _____
 Insurance: _____ Policy #: _____
 Gender: _____ Race: _____ Ethnicity: _____

- Yes or** **No** Is your child 12 years old or older?
- Yes or** **No** Does your child have a history of severe allergic reactions (requiring epinephrine or resulting in hospitalization) after receiving a vaccine or other injectable?
- Yes or** **No** Has your child received passive antibody therapy as treatment for COVID-19 in the last 90 days?
- Yes or** **No** Has your child received any other vaccine within the last 14 days, or plan to receive any other vaccine in the next 14 days?
- Yes or** **No** Has your child received any dose of COVID-19 vaccine?
 If **YES**, which COVID-19 Vaccine has the child received?
 Pfizer-BioNTech Moderna AstraZeneca Not Sure

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- Yes or** **No** Is your child currently feeling sick or ill??
- Yes or** **No** Is your child currently pregnant or plan to become pregnant?
- Yes or** **No** Is your child currently breastfeeding?
- Yes or** **No** Is your child immunocompromised or take any medications that affects their immune system?
- Yes or** **No** Does your child have a bleeding disorder or are they on a blood thinner?
- Yes or** **No** Has your child tested positive for COVID-19 in the past 14 days?

In providing my consent below, I agree that:

1. I have been provided the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers, and understand the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
3. I give consent to administer the Pfizer-BioNTech COVID-19 Vaccine to the child named above whether or not I am present at the vaccination appointment and understand that I am not required to accompany the child named above to their vaccination appointment.
4. The government is paying for the Pfizer-BioNTech COVID-19 Vaccine itself, and I will not be billed for the vaccine. However, the government is not covering the cost of administering the vaccine. If I have health insurance that covers me or my child, I give permission for my insurance company to be billed for the costs of administering the vaccine to my child. If I do not have insurance, I will not be billed for the administration.
5. I give permission for a record of the vaccination to be entered into Centricity EMR and sent to the Maine Immunization Information System, ImmPact Registry.

Parent/Legal Guardian Name: _____
 Parent/Legal Guardian Signature: _____ Date: _____

Office Use Only Below This Line

Child's Name: (Print) _____ Date of Birth: _____

COVID-19 EUA fact sheet given: Yes No **Medication:** Pfizer-BioNTech **Date Given:** / /2021

Route: IM **Site:** R Deltoid L Deltoid **Time Given:** _____

Lot #: _____ **Expiration Date:** _____ **NDC #:** _____ Dose 1 Dose 2

Given By: _____