**Consent for Covid-19 Vaccine For My Child Under 12 Years Old**

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby attest to the following:

* I am the parent or legal guardian of the minor child.
* The minor patient is 6 months of age or older.
* I have the legal authority to consent to the administration of the Moderna 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 Moderna Covid-19 Vaccine for children over 6 months of age.
* I have been provided access to the COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers which is available in our exam room or on our website at [www.CatalinaPediatrics.com](http://www.CatalinaPediatrics.com)
* I understand the known and potential risks and benefits of the COVID-19 Vaccine and the extent which such risks and benefits are unknown.
* 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 and anaphylaxis.
* The minor patient and I agree to remain in the observation area for the required time period following vaccine dose administration.

**Precautions/Contraindications:** Please circle **No** or **Yes**

Fever or feeling ill today? **No Yes** – Defer until feeling better.

Have you ever received a dose of COVID-19 **No Yes** – Ensure appropriate interval.

Vaccine?

History of severe allergic reaction (anaphylaxis) **No Yes** – STOP. Do NOT vaccinate.

to any component of this vaccine?

History of severe allergic reaction (anaphylaxis) **No Yes** – Requires 30 minute observation.

to another vaccine?

History of severe allergic reaction (anaphylaxis) **No Yes** – Requires 30 minute observation.

to injectable therapy?

History of severe allergic reaction (anaphylaxis) **No Yes** – Requires 30 minute observation.

due to any cause?

Are you getting allergy immunotherapy shots? **No Yes** – Defer vaccine if has had shot within

 72 hours.

**Printed Name of Parent/Guardian Consenting**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Guardian Consenting**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_