

# Voluntary Consent To COVID-19 Vaccine for my Minor Child

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 5 years of age or older
- 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 for children ages over 5.
- I have been provided access to and have read the Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers which is available at <https://www.fda.gov/media/144414/download> or on our website at Catalina Pediatrics.
- I understand the known and potential risks and benefits of the COVID-19 Vaccine and the extent to which such risks and benefits are unknown.
- I understand that the Pfizer-BioNTech COVID-19 Vaccine is a two part vaccine series given approximately three weeks apart to the minor patient.
- 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 Vaccine?	No	Yes — Ensure same vaccine and appropriate interval
History of severe allergic reaction (anaphylaxis) to any component of this vaccine?	No	Yes — STOP. Do NOT vaccinate
History of severe allergic reaction (anaphylaxis) to another vaccine?	No	Yes — Requires 30 minute observation
History of severe allergic reaction (anaphylaxis) to injectable therapy?	No	Yes — Requires 30 minute observation
History of severe allergic reaction (anaphylaxis) due to any cause?	No	Yes — Requires 30 minute observation
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 \_\_\_\_\_