



**Unaccompanied Minor Patient  
VACCINATION CONSENT**

**Patient Name** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_

**Address** \_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Does the patient have any allergies? Yes No**

**If yes, please list:** \_\_\_\_\_

1. Are you feeling sick today?  Yes  No
2. Have you ever received a dose of COVID-19 vaccine?  Yes  No  
If yes, which vaccine product? \_\_\_\_\_
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past?  
*Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?*  Yes  No
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?  Yes  No
6. Do you have a bleeding disorder or are you taking a blood thinner?  Yes  No
7. For women, are you currently pregnant or breastfeeding?  Yes  No

I acknowledge I have read and consent to the following:

**For individuals 16 years or older,**

the FDA has granted full approval for the administration of the Comirnaty (Pfizer/BioNTech) COVID-19 vaccine. I have received a copy and have read, or had explained to me, the vaccine information sheet about the Comirnaty COVID-19 vaccination.

**For individuals ages 5-15,**

the FDA has made the Comirnaty (Pfizer/BioNTech) COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not yet completed the same type of review as an FDA-approved or cleared product for this age group. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. I have reviewed this consent form, and I understand that the "Fact Sheet for Recipients

and Caregivers”includes more detailed information about the potential risks and benefits of the Comirnaty (Pfizer-BioNTech) COVID-19 vaccine for individuals between 12 and 15 years old.

I certify that to the best of my knowledge and belief, the information I have provided is true, correct, and complete. I understand there will be no cost to me for this vaccine. I authorize the CIMPAR staff to collect and use all personal and demographic data supplied by me for other public health purposes, including reporting to applicable vaccine registries. I authorize the CIMPAR staff to examine me/my child and administer any medical treatment as may be advisable.

I understand that this vaccine requires two doses in order for it to be effective. I have been given an opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that the vaccine be given to me, or the person named on this form for whom I am authorized to make this request. My signature indicates that I fully understand the above information.

I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

I understand I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child will receive the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment. If a medical emergency occurs and a parent or legal guardian is not present, I authorize the medical provider to call 9-1-1 to request emergency medical services. I accept any and all fees and costs incurred for emergency medical services and other medical care.

**I GIVE CONSENT for the child named in this registration to be vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to all information included in this registration (If this consent is not signed the child will not be vaccinated.)**

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***Must be filled out by vaccinator:***

*This consent form does not replace registration in Juvare/EMTrack. Patients under the age of 18 are only eligible to receive the Pfizer vaccine at this time.*

*Clinic Site:* \_\_\_\_\_

*Vaccinator Initials:* \_\_\_\_\_ *Date:* \_\_\_\_\_