Consent and Administration Record – COVID-19 Immunization Clinic – Pfizer Minor Consent: AGE 12-17

Health Department Address:

PARENT/GUARDIAN NAME: ______________________________

CHILD NAME: ______________________________

Information about Child Receiving Vaccine(s) – Please Print				
Last Name:		**First Name:**		**MI:**
Street Address:		**City:**	**State:** WI	**Zip:**
Date of Birth (MM/DD/YY):	**Age:**	**Mother's Maiden name**		
Gender: ☐ Male ☐ Female ☐ Transgender – Male to Female ☐ Transgender – Unspecified or Gender Non-Specific ☐ Transgender – Female to Male ☐ Prefer not to Answer ☐ Other _______				
Race: (check all that apply) ☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ African American or Black ☐ Native Hawaiian or other Pacific Islander ☐ Prefer not to Answer ☐ Other_________ ☐ Multi-race			**Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to Answer	
Parent / Legal Guardian Last Name:	**First Name:**		**Phone Number:** (Where you can be reached on date of clinic)	

Administered immunizations are entered and visible in WIR: name, date, vaccine brand, dose, lot number, exp date
Maintain this consent form and bring to second vaccine dose administration, regardless of location.

The following questions will help us to determine if there is any reason your child should not receive the COVID-19 vaccine. If you answer "yes" to any questions, it does not necessarily mean that your child should not be vaccinated. It just means that additional questions must be asked for your child's safety.

	Questions about the child receiving vaccine:	**Yes**	**No**
1	Is the child currently in isolation or quarantine period due to COVID-19?		
2	Has the child ever received a dose of COVID-19 vaccine?		
3	Has the child ever had a severe allergic reaction (anaphylactic) to any food, medication, vaccine, or previous COVID-19 vaccine? List:______________________________		
4	Has the child received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?		
5	Has the child received any vaccines in the past 14 days?		
6	Is the child pregnant or breastfeeding?		

I understand the benefits and risks of the vaccine and ask that the vaccine be given to the child listed above for whom I am authorized to make this request.

☐ **Pfizer COVID-19 vaccine (both doses in a 2-dose series, separated by 3 weeks) for ages 12-17**

______________________________ ______________

Signature of Parent/Legal Guardian Date Signed

______________________________ ______________

Printed Name of Parent/Legal Guardian Relationship to Child

For Office Use Only

Date/Time	Dose	Vaccine	Lot Number	Expiration Date	Site	Signature & Title – person administering vaccine
	☐ 1ST Dose ☐ 2nd Dose	Pfizer COVID-19 0.3 mL IM			☐ RD ☐ LD	MM/DD/YYYY

Second Dose Information: **Date**: __________________**Time**:___________ **am/pm**

Comments:

Date EUA fact sheet for recipients and caregivers provided to parent/guardian: