



Pfizer-BioNtech COVID-19 Vaccine Consent For Individuals Under 18 Years of Age



Section 1: Information about the child to receive Pfizer-BioNtech COVID-19 Vaccine (please print):

Child's Name (Last, First, Middle)		Date of Birth (mm/dd/yyyy)			Age
Street Address		City	State	Zip	Phone Number
Sex:	Male Female	Ethnicity:	Hispanic	Not Hispanic	Language(s) spoken at home
Race:	White Asian	Black/African American	Hawaiian/Pacific Islander	Two or more races	
American Indian/Alaska Native					

Section 2: Information on the risks and benefits of the Pfizer-BioNtech COVID-19 Vaccine (Pfizer Vaccine). Currently the U.S. Food and Drug Administration (FDA) has approved the use of the Pfizer Vaccine to prevent COVID-19 in individuals 12 years of age and older. To learn more about risks, benefits, and side effects of the Pfizer vaccine, read the U.S. Food and Drug Administration's [Fact Sheet for Recipients and Caregivers](#).

Section 3: Please Answer the Following Questions About the Person who will get the COVID-19 vaccine (please mark yes or no):

Yes No

Are you feeling sick today?

Have you ever received a dose of COVID-19 vaccine?

Have you ever had an allergic reaction to (1) component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, (2) Polysorbate, (3) a previous dose of COVID-19 vaccine (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.

Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?

Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?

Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

Do you have a bleeding disorder or are you taking a blood thinner?

Do you have a history of heparin-induced thrombocytopenia (HIT)?

Are you pregnant or breastfeeding?

Have you received dermal fillers?

Do you have a history of myocarditis or pericarditis?



Section 4: Consent.

I have reviewed the information on risks and benefits of the Pfizer Vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named above to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the [Request to Lock My CAIR Record](#) web form.
5. I have read or had explained to me the Pfizer Vaccine Information Statement. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Pfizer vaccine and request that it be given to me or the person for whom I am authorized to make this request.
6. I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer- Biotech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Name (Last, First, Middle)

Signature Date

Address if different from above

Phone Number if different from above

Staff Use Only! CAIR Disclosure form Registry # _____

Services provided by: _____ / _____
Nurse administering vaccination (name) Nurse administering vaccination (signature)

If medical condition exists, print here _____

Date	Time	Clinic	Lot #/ Exp Date	Injection Site (Circle)	Route	VIS Date
				RD LD	IM	8/23/2021

Vaccine type/dose administered: Pfizer COVID 19 Dose No. Dose: 0.3ML