



CONSENT TO VACCINATION AND RELATED TREATMENT FOR MINOR WITHOUT A PARENT/LEGAL REPRESENTATION

Consent is required for vaccination of patients under the age of 18 without a parent/legal representative present.

Minor Patient Name:	Minor Patient Date of Birth:
Minor Patient Address:	
Emergency Contact: Name: _____ Relationship to Minor: _____ Phone Number: _____	

I am the: ___ Parent of the minor patient ___ Legal guardian of the minor patient
 ___ Other person with authority to make healthcare decisions on behalf of the minor patient, describe legal relationship: _____

I hereby attest to the following:

- The patient is a minor and eligible for the COVID VACCINE
- I have the legal authority to consent to the administration of the COVID VACCINE to the minor patient
- I understand that I have the option to accept or refuse COVID VACCINE on behalf of 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, anaphylaxis, and other reactions.
- The minor patient and I agree that the minor patient will remain in the observation area for the required time period following vaccine dose administration.
- I consent to the administration of the COVID VACCINE

PLEASE CIRCLE WHICH VACCINE YOU ARE AUTHORIZING TO BE ADMINSTERED

COVID VACCINE

Printed Name of Parent, Legal Guardian, or Other Authorized Individual

Date

Signature of Parent, Legal Guardian, or Other Authorized Individual

Date

