



**CONSENT FOR COVID-19 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 a COVID-19 Vaccine
- I have the legal authority to consent to the administration of a COVID-19 Vaccine to the minor patient
- I have been provided access to and read the COVID-19 VIS at the following website:
 <https://www.cdc.gov/vaccines/hcp/vis/index.html>.
- I understand the known and potential risks and benefits of a COVID-19 Vaccine and the extent to which such risks and benefits are unknown.
- I understand that I have the option to accept or refuse a COVID-19 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 the COVID-19 Vaccine.

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

Signature of Parent, Legal Guardian, or Other Authorized Individual Date