# Consent to Administer COVID-19 Vaccination to a Minor

**Minor** Patient Name: _____DOB: _____/_____/_____
Age: _____ Gender: _____

Street Address: _____ Town/City: _____
County:_____ State: _____ Zip: _____

Ethnicity: ☐Non-Hispanic ☐Hispanic ☐Unknown ☐ Decline to Specify

Race (check all that apply): ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐White ☐Unknown ☐Decline

| **SCREENING QUESTIONS** | **YES** | **NO** | **Unknown** |
|---|---|---|---|
| Are you feeling sick today? | | | |
| Have you ever received a dose of a COVID-19 vaccine before?<br>**If yes,** which COVID-19 vaccine product(s) were you previously given?<br>☐ Pfizer-BioNTech 5-11 year ☐ Pfizer-BioNTech 12-17 ☐ Moderna | | | |
| Did you have an allergic reaction after a prior dose of COVID-19 vaccine?<br>*Allergic reactions can include symptoms like rash, hives, swelling of face or mouth, wheezing and difficulty breathing, etc. – Please specify:*<br>_____ | | | |
| Do you have a known allergy to an ingredient in the Pfizer-BioNTech COVID-19 vaccine? *See the provided age-appropriate FDA Fact Sheet for a list of vaccine ingredients.* | | | |
| Do you have a known allergy to polyethylene glycol (PEG)? Or polysorbate | | | |
| Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)? | | | |
| Have you ever had a severe allergic reaction (like anaphylaxis due to any other cause, including to medications taken by mouth, food, or other substances? | | | |
| Did you develop myocarditis or pericarditis after receiving a prior dose of the Pfizer-BioNTech?<br>Do you have a bleeding disorder or are you taking blood thinners? | | | |
| In the last 90 days, have you been given a COVID-19 antibody therapy to either treat COVID-19, or to prevent COVID-19 from developing after you were exposed to another person with COVID-19? *(Antibody therapies include monoclonal antibodies or a blood product called "convalescent plasma")* | | | |

I hereby acknowledge the following: (please initial)

_____ I have completed the appropriate health screening questionnaire prior to vaccination and have no known contraindications to this vaccination.

_____ I have been provided with a copy of, and reviewed the contents of, the age-appropriate FDA Fact Sheet for people receiving the COVID-19 vaccine.

_____ I acknowledge that I have received and reviewed the information provided and I confirm that the information entered on this form is accurate to the best of my knowledge.

_____ I acknowledge that I am required to wait a minimum of 15 minutes after administration of the vaccination before leaving the vaccination site.

I acknowledge the above statements to be true and accurate to the best of my knowledge regarding the aforementioned vaccine recipient.

**Signature of Parent/legal Guardian/Foster Parent/Residential Staff**:

_____

**Printed Name of Parent/legal Guardian/Foster Parent/Residential Staff**:

_____ **Date**: _____

I understand, as a condition of receiving the COVID-19 vaccine today, my personal health information, or that of my child/ward, may be shared as allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (see DHHS Notice of Privacy Practices).

I understand unless I have **SIGNED THE SEPARATE** *Choose not to Participate in the NH Immunization/Vaccination Registry* form exercising my right to opt out under NH RSA 141-C:20-f, and NH Administrative Rule He-P 307.06, and have checked the box below, my immunization information will also be entered into the NH Immunization/Vaccination Registry.

☐ I choose **NOT** to participate in the NH Immunization/Vaccine Registry (MUST COMPLETE SEPARATE FORM)

**I consent to the administration of the Vaccine by State of New Hampshire Regional Public Health Department (NH RPHN). I fully release and discharge NH RPHN, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or receipt of, the Vaccine.**

**Signature of Parent/Legal Guardian: _____**

**Printed Name of Parent/Legal Guardian: _____**

**Date: _____/_____/_____Phone Number: _____**

**Relationship to Minor: _____**

**Email Address:_____**

**Vaccine:_____ Lot #: _____ Exp Date:_____**

**Dose amount: _____ Site: _____ Date Admin: _____Time Given: _____**

**Admin by: _____Clinic Name: _____**