PREVEA health

Patient label

COVID 19 Vaccination Consent for Minors (16-17 years old)

PATIENT'S NAME_____ (please print) **Date of Birth: _____**

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

The Pfizer COVID 19 vaccine is a series of two (2) injections. The vaccinations must be spaced apart based on manufacture and FDA guidelines. Please ensure that the above-named patient can complete the series before consenting to this vaccine administration.

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

Attached is a Fact Sheet from Pfizer. Please read the attached Fact Sheet completely and carefully.

Individuals who are currently ill and/or have a fever should not be vaccinated until symptoms have subsided.

CONSENT

I, the parent or legal guardian of the patient, hereby consent to the administration of two injections of the Pfizer COVID-19 virus vaccine for the above-named patient. I have read the above statements pertaining to the Pfizer COVID-19 virus vaccine and the attached Fact Sheet. I have been advised of and understand the risks, side effects, benefits and alternatives to the above-named patient receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in the above-named patient. I have been advised and understand the vaccine is a series of two injections and I intend for the above-named patient to complete the series of injections. **I understand that I am voluntarily consenting to the above-named patient to receive the vaccine and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that the above-named patient will not realize the benefit of the vaccine if I refuse or decline to have the above-named patient receive the second injection.**

I understand that Prevea may contact me to confirm my consent in Prevea's discretion, to obtain additional information that Prevea may need pertaining to the above-named patient, or otherwise as necessary in the event of an emergency. I further understand that Prevea may decline to provide the vaccination if the requested Contact information is not provided below.

Signature:

_____ _____ _____

Signature of Parent or Legal Guardian | Date | Printed name of Parent or Legal Guardian

_____

Parent or Legal Guardian (circle one)

Contact Information:

Cell Phone: _____

Home Phone: _____

Office Phone: _____