

## CONSENT TO 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 Pati    | ent Name:   | Minor Patier            | nt Date of Birth:                             |
|---------------|---|-------------------------|---|
| Minor Pati    | ent Address:  |                         |   |
| Emergency     | Contact:  |                         |   |
|               |   |                         |   |
| Relationsh    | hip to Minor:   |                         |   |
| Phone Nu      | mber:   | _                       |   |
| I am the:     | Parent of the minor patient   | Legal guardiar          | of the minor patient                          |
|               | Other person with authority to make h describe legal relationship:                        |                         | •   |
| I hereby atte | est to the following:   |                         |   |
| • The         | patient is a minor and eligible for the Pfize   | r-BioNTech or Moder     | na COVID-19 vaccine.                          |
|               |   | ministration of the Pf  | izer-BioNTech or Moderna COVID-19 vaccin      |
|               | ne minor patient.   | iniatuation ("FDA") ba  |   |
|               | derstand that the U.S. Food and Drug Adm<br>er-BioNTech COVID-19 and Moderna vacci        | · · · · · ·             | is authorized the emergency use of the        |
|               | ve been provided access to and read the re  |                         | cine EUA Fact Sheet for Recipients and        |
|               | egivers ("Fact Sheet").   |                         |   |
|               | derstand the known and potential risks and<br>extent to which such risks and benefits are |                         | oNTech or Moderna COVID-19 vaccines and       |
|               | derstand that I have the option to accept of  |                         | scine on behalf of the minor patient.         |
|               | derstand that the Pfizer-BioNTech and Moo   |                         | •   |
| • I cor       | nsent to and authorize all medically necess   | sary treatment in the   | rare event that the minor patient has a       |
| reac          | tion to the vaccine, including but not limit  | ed to itching, swelling | g, fainting, anaphylaxis and other reactions. |
|               |   | patient will remain in  | the observation area for the required time    |
|               | od following vaccine dose administration.   | Tools on Madama COV     | UD 10 vecsine including any                   |
|               | nsent to the administration of Pfizer-BioNT<br>itional required doses to complete the ser |                         | 71D-19 vaccine, including any                 |
| Printed Nam   | ne of Parent, Legal Guardian, or Other Auth   | norized Individual      | Date  |
|               | Parent, Legal Guardian, or Other Authoriz   | ed Individual           | <br>Date                                      |



## COVID-19 Vaccine Screening Questions For Minors Without Parent/Guardian Present Preguntas de Asesoría de COVID-19 Para Menores Sin sus Padres/Tutores Presentes

Please answer the following questions on behalf of your child if your child is coming to their vaccine appointment without a parent or guardian.

Por favor, responda las siguientes preguntas si su hijo/ja llegara a la cita de vacuna sin sus padres/tutores.

| Minor Patient Name: |  | Minor Patient<br>Date of Birth: |          |         |
|---------------------|--|---------------------------------|----------|---------|
| Minor Pat           | tient Address:   |                                 |          |         |
| Screenir            | ng Question  |                                 | Yes / Sí | No / No |
|                     | Do you give consent to receive the COVID-19 vaccine today?  Da su consentimiento para recibir la vacuna COVID-19 hoy?                  |                                 |          |         |
|                     | re you feeling sick today?<br>Se siente enfermo(a) hoy?  |                                 |          |         |
|                     | ave you ever received a dose of the COVID-19 vaccine?  a. If yes, which vaccine did you receive and on what date?  Vaccine Name: Date: |                                 |          |         |
| ¿Hi                 | a recibido alguna vez una dosis de la vacuna COVID-19?  a. Nombre de la Vacuna: Fecha  | :                               |          |         |
| 4. Aı               | re you immunocompromised or taking medications that affect you a. If yes, please explain and list medications:                         |                                 |          |         |
| 15                  | Está inmunocomprometidos o tomando medicamentos que afectar<br>a. Si la respuesta es SI, explique y liste las medicaciones:            |                                 |          |         |
| 5. Ha               | ave you ever had a severe allergic reaction (e.g., anaphylaxis) to ar a. If yes, please explain:                                       |                                 |          |         |
| Ċ.                  | Alguna vez ha tenido una reacción alérgica grave (p. ej., anafilaxia)<br>a. Si la respuesta es SI, explique:                           | _                               |          |         |