



## Pfizer-BioNTech COVID-19 Vaccine Consent For Individuals Under 18 Years of Age

I have been given a copy of and have read, or have had explained to me, the information contained in the FDA Emergency Use Authorization (EUA) Recipient Fact Sheet for the Pfizer COVID-19 vaccine for persons 12 years and older:

<https://www.fda.gov/media/144414/download>

1. I reviewed this consent form and understand the risks and benefits of the Pfizer Vaccine.
2. I have the legal authority to consent to have the child named below vaccinated with the Pfizer Vaccine.
3. I understand I am not required to accompany the child named below to the vaccination appointment and, by giving my consent below, the child will receive the Pfizer Vaccine whether or not I am present at the vaccination appointment.
4. By signing below, I acknowledge I have been made aware of the Notice of Privacy Practices of Santa Barbara County Public Health Department. It is available at <https://countyofsb.org/ceo/hipaanoticesofprivacy.sbc>. It provides information about how Santa Barbara County Public Health Department uses and discloses protected health information.
5. I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the [Request to Lock My CAIR Record](#) web form.
6. By providing my cell phone number and/or email address below, I give the Santa Barbara County Public Health Department and participating vaccination partners permission to contact me regarding important vaccine reminders.

Please complete both pages, sign, and date.

**Child's First Name:** \_\_\_\_\_

**Child's Last Name:** \_\_\_\_\_

**Birthdate:**  
mm/dd/yyyy \_\_\_\_\_

**Gender:**  Male  Female  Other

**Parent/Guardian First Name:** \_\_\_\_\_

**Parent/Guardian Last Name:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Contact Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**Zip code:** \_\_\_\_\_



<b>Screening Questions</b> <b>Please Answer the Following Questions (check one)</b>		
1	Have you ever received a dose of COVID-19 Vaccine? If Yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson&Johnson)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Are you feeling sick?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Have you ever had an allergic reaction to: 1. Component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, 2. Polysorbate, 3. A previous dose of COVID-19 vaccine (this would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (this would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of the COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you received any vaccine in the last 14 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I GIVE CONSENT for the child named above to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

\_\_\_\_\_  
Signature of Parent/Guardian or Caregiver

\_\_\_\_\_  
Date