COVID-19 Vaccine Consent
For Individuals 5-11 Years of Age

Section 1: Information about the child to receive COVID-19 Vaccine (please print):

Child's Name (Last, First, Middle) Date of Birth (mm/dd/yyyy) Age

Street Address City State Zip

Phone Number

Section 2: Information on the risks and benefits of the COVID-19 Vaccine

Currently the U.S. Food and Drug Administration (FDA) has authorized emergency use of the vaccine to prevent COVID-19 in individuals 5-11 yr olds. The FDA has not yet approved licensure of vaccine to prevent COVID-19. To learn more about risks, benefits, and side effects of the vaccine, I have been given, read, and understood the U.S. Food and Drug Administration's Recipients and Caregivers 5-11 years of age (fda.gov)

Section 3: Consent.

I have reviewed the information on risks and benefits of the vaccine in Section 2 above and understand the risks and benefits. I agree that:

1. I reviewed this consent form and have read and understand the Fact Sheet for Recipients and Caregivers about the potential risks and benefits of the vaccine.
2. I have the legal authority to consent to have the Child named above vaccinated with the COVID-19 vaccine.
3. I understand I am not required to accompany the Child named above to the vaccination appointment and, by giving my consent below, the Child will receive the COVID-19 vaccine whether or not I am present at the vaccination appointment.

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

Name (Last, First, Middle)

Signature Date

Relationship to the Child named above

Address if different from above

Phone Number if different from above

Email Address (To receive any additional information of El Paso Children's Hospital)

For Clinician Use Only

TO BE COMPLETED BY ADMINISTRATION TEAM:

1st Dose Date: _____ **2nd Dose Due:** _____

Manufacturer: _____ Lot#: _____ Expiration Date: _____

Injection Site: Deltoid: (circle location) RIGHT / LEFT

Name of Person Administering Vaccine: _____

Signature: _____ Title: _____

2nd Dose Date: _____

Manufacturer: _____ Lot#: _____ Expiration Date: _____

Injection Site: Deltoid: (circle location) RIGHT / LEFT

Name of Person Administering Vaccine: _____

Signature: _____ Title: _____