CONSENT TO 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 Patient Name:	**Minor Patient Date of Birth:**
Minor Patient Address:	
Emergency Contact: Name: ____ Relationship to Minor: __________________________________ Phone Number: ______________________________	

I am the: ___ Parent of the minor patient ___ Legal guardian of the minor patient

___ Other person with authority to make healthcare decisions on behalf of the minor patient, describe legal relationship: ____

I hereby attest to the following:

- The patient is a minor and eligible for the COVID or INFLUENZA VACCINE
- I have the legal authority to consent to the administration of the COVID or INFLUENZA VACCINE to the minor patient
- I understand that I have the option to accept or refuse COVID or INFLUENZA VACCINE on behalf of the minor patient.
- I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine, including but not limited to itching, swelling, fainting, anaphylaxis, and other reactions.
- The minor patient and I agree that the minor patient will remain in the observation area for the required time period following vaccine dose administration.
- I consent to the administration of the COVID or INFLUENZA VACCINE

PLEASE CIRCLE WHICH VACCINE YOU ARE AUTHORIZING TO BE ADMINSTERED

COVID VACCINE **INFLUENZA VACCCINE**

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Printed Name of Parent, Legal Guardian, or Other Authorized Individual Date

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Signature of Parent, Legal Guardian, or Other Authorized Individual Date