



Covid-19 Booster Consent Form: Ages 5 and Up

Patient's Name: _____ PCP: _____

DOB: _____ Age: _____ yrs

Date of 1st and 2nd primary series: 1st _____ 2nd _____

Has the child to be vaccinated:	Yes	No	Don't Know
Felt sick today?			
Ever had anaphylaxis to anything?			
Had/has a bleeding disorder?			
Had/has a history of myocarditis?			
Had Covid monoclonal antibody treatment?			
Been diagnosed with MIS-C?			
Taken/taking a blood thinner?			

**Please click the link below to review the EUA for the Pfizer Covid Booster

[EUA Link](#)

For office use:

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LD RD

Vax initials:

I have reviewed the EUA and consent to vaccination for my child, named above.

Parent Signature: _____

Parent Name (printed): _____

Date of Vaccination: _____

*** Please print out form for **each child** to be vaccinated and bring in on your vaccination date. Please bring a mask and your vaccine card for each person coming into clinic as well. Thank you!