



Covid-19 Vaccination Consent Form

Child's Name: _____ PCP: _____

DOB: _____ Age: _____

Has the child to be vaccinated:	Yes	No	Don't Know
Felt sick today?			
Received a prior Covid Vaccine?			
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 see our website for the EUA Links for your child's age group and type of vaccine

[EUA Links](#)

For office use:

15 30

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 for each person coming into clinic as well. Thank you!