



## COVID-19 VACCINATION AUTHORIZATION FOR A MINOR

Client # \_\_\_\_\_ Date: \_\_\_\_\_

<b>Please Print</b>			
Minor's Legal Name: _____			
<i>Last</i>		<i>First</i>	<i>Middle</i>
<b>MUST BE AT LEAST 16</b>		Other Name Used: _____	
Minor's Birth Date: _____ / _____ / _____ AGE _____			
<i>Month / Day / Year</i>			
Minor's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female    Race/Ethnicity: <input type="checkbox"/> Native Amer. <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other			
Address: _____			
<i>Street</i>		<i>City</i>	<i>Zip</i>
Primary Telephone: ( _____ ) _____		County of Residence: <input type="checkbox"/> Muskegon <input type="checkbox"/> Other: _____	
<b>Please Print:</b>			
Parent/Legal Guardian's Name: _____			
<i>Last</i>		<i>First</i>	<i>Middle</i>
Parent's Birth Date: _____ / _____ / _____ AGE _____		Maiden/Other Name Used: _____	
<i>Month / Day / Year</i>			
<p>The following questions will help us determine if there is any reason the minor should not receive the COVID-19 vaccine today. If you answer "yes" to any questions, it does not necessarily mean the minor should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.</p>			
	YES	NO	DON'T KNOW
1. Is the minor feeling sick today?			
2. Have they ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> <li>• If yes, what was the date and which vaccine product? Date: _____</li> <li><input type="checkbox"/> BioNTech (Pfizer) <input type="checkbox"/> Another Product _____</li> </ul>			
3. Have they ever had an allergic reaction to			
<ul style="list-style-type: none"> <li>• A component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine</li> <li>• A vaccine or injectable therapy that contains multiple components.</li> </ul>			
4. Have they ever had an allergic reaction to another vaccine or an injectable medication?			
5. Have they ever had a severe allergic reaction to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental or oral medication allergies?			
6. Have they received any vaccinations in the past 14 days?			
7. Have they ever had a positive test for COVID-19 or has a doctor ever told you that they had COVID-19?			
8. Have they received passive antibody therapy as treatment for COVID-19?			
9. Do they have a weakened immune system caused by something such as cancer, leukemia, AIDS, any other immune system problem or do they take immunosuppressive drugs or therapies?			
10. Do they have a bleeding disorder or are you taking a blood thinner?			
11. Are they pregnant or breastfeeding?			
12. Do they have dermal fillers?			

To Be Completed By Parent/Legal Guardian	INITIAL
1. I certify that I am the parent or legal guardian of the minor listed above.	
2. I certify that they are at least 16 years of age.	
3. I acknowledge that we received a copy of the EUA Fact Sheet for Recipients and Caregivers.	
4. I confirm that I have read the above Fact Sheet.	
5. I understand, that they should receive a 2nd dose of the vaccine and will do so when scheduled.	
6. I understand that the COVID-19 vaccine is available under an emergency access mechanism called an EUA and has not undergone the same type of review of FDA approved or cleared products.	
7. I have been given the opportunity to ask questions before I sign.	
8. I authorize the public health official to administer the COVID-19 Vaccination.	

I, the undersigned, have been informed about the purpose, procedures and possible benefits and risks of the minor above receiving the vaccine. I have been given the opportunity to ask questions before I sign and I have been told that I can ask other questions at any time. I confirm that I am the parent or legal guardian of the minor listed above and voluntarily agree to have them receive the COVID-19 vaccination.

Client/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Office Use Only**

Vaccination Administration Information		
Manufacturer:	<input type="checkbox"/> Pfizer <input type="checkbox"/> Other: _____	Time Administered:
Lot Number:	Site: <input type="checkbox"/> L <input type="checkbox"/> R	Route:
Name (Print):		
Title:		
Signature:		