



# COVID-19 Vaccine Consent Form for Individuals 5-17 Years of Age

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

\_\_\_\_\_

*Child's Name (Last, First, MI)*

\_\_\_\_\_

*Date of Birth  
(mm/dd/yyyy)*

\_\_\_\_\_

*Age*

\_\_\_\_\_

*Street Address*

\_\_\_\_\_

*City*

\_\_\_\_\_

*State*

\_\_\_\_\_

*Zip*

\_\_\_\_\_

*Phone Number*

## Section 2: Information about the Pfizer Vaccine

Your child is being offered a COVID-19 vaccine made by Pfizer-BioNTech. The Pfizer-BioNTech COVID-19 Vaccine is approved by the U.S. Food and Drug Administration (FDA) for people over 16 years old, with the brand name Comirnaty. The FDA has also issued an Emergency Use Authorization for Pfizer-BioNTech COVID-19 Vaccine: (i) for primary series vaccination in people ages 5 and older, (ii) as a single booster dose at least 5 months after completing the primary series in individuals 12 years and older; and, (iii) as a third primary series dose of vaccine at least 28 days after the second dose in immunocompromised individuals 5 years and older. Both the Pfizer-BioNTech COVID-19 Vaccine and Comirnaty are administered as a 2-dose series, 3 weeks apart, into the muscle.

The vaccine provider will need certain information about your child's medical history before administering the vaccine. Those questions are available here [www.mass.gov/CDCScreeningForm](http://www.mass.gov/CDCScreeningForm).

The vaccine may not protect everyone from COVID-19 disease. Some people may experience side effects after getting the vaccine. Side effects that have been reported include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever,

<sup>1</sup>For this vaccine, "immunocompromised" includes individuals who have undergone solid organ transplant or who are diagnosed with conditions considered to have an equivalent level of immunocompromise.



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injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine. For this reason, a vaccination provider may ask the person receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body.

Additional information is available in the Pfizer-BioNTech COVID-19 Vaccine “Fact Sheet for Recipients and Caregivers” available at:

- [Recipients and Caregivers 5-11 years of age \(fda.gov\)](https://www.fda.gov/oc/ohrt/2020-08-14-pfizer-biontech-covid-19-vaccine-fact-sheet-recipients-and-caregivers-5-11-years-of-age)
- [Recipients and Caregivers 12 years of age and older \(fda.gov\)](https://www.fda.gov/oc/ohrt/2020-08-14-pfizer-biontech-covid-19-vaccine-fact-sheet-recipients-and-caregivers-12-years-of-age-and-older)

## Section 3: Consent

**CONSENT FOR MINOR'S VACCINATION:** I have reviewed the information about the Pfizer-BioNTech and Comirnaty COVID-19 Vaccines in **Section 2** above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the “Fact Sheet for Recipients and Caregivers,” includes more detailed information about the potential risks and benefits of the Pfizer-BioNTech and Comirnaty COVID-19 Vaccines.
2. I have the legal authority to consent to have the child named above vaccinated with the Pfizer-BioNTech or Comirnaty COVID-19 Vaccine.
3. I understand I am not required to accompany the child named above to their vaccination appointment and that, by giving my consent below, the child will receive the Pfizer-BioNTech or Comirnaty COVID-19 Vaccine whether or not I am present at the vaccination appointment.
4. If I have health insurance that covers the child named above, I give permission for my insurance company to be billed for the costs of administering the Pfizer Comirnaty COVID-19 Vaccine. The government is paying for the Pfizer Comirnaty COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
5. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis), for information on the MIIS and what to do if I object to my or my family's data being shared with other providers in the MIIS.

**I GIVE CONSENT** for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech or Comirnaty COVID-19 Vaccine and have reviewed and agree to the information included in **Section 3** of this form. (If this consent is not signed, dated, and returned, the child will not be vaccinated.)

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*Signature of Legally Authorized Representative*

*Date*