COVID VACCINE CONSENT FORM

Patient Name:

DOB:

Date:

Vaccines

☐COVID-19 mRNA – Pfizer Tender Age 6 mo – 4 yro

☐COVID-19 mRNA – Pfizer Pediatric 5 – 11 yro

☐COVID-19 mRNA – Pfizer Adolescent/Adult 12 yro & older

I have read or have had explained to me information about the vaccines listed above. I understand the benefits and risks of the vaccines cited and ask that the vaccine(s) be given to _____ for whom I am authorized to give consent.

(PATIENT NAME)

x

_____

Signature of Patient/Guardian