Pediatric Dream Care
3199 Lake Worth Road B-2
Palm Springs, Fl 33461
561-621-1801
561-331-4603
pediatricdreamcare@gmail.com

COVID-19 VACCINE PARENTAL CONSENT FORM

Patient's Name: _____Patient's DOB: _____

Name of Parent/Legal Guardian: _____

Phone number of Parent/Legal Guardian:_____

The vaccine to be Administered:_____Date of Administration _____/____/_____

I certify that I am the parent or legal guardian of the patient and confirm that the patient is at least the minimum age to receive this vaccine. I am authorized to consent to vaccination for the patient named above. Furthermore, I hereby give my consent to Pediatric Dream Care or their agents to administer the Covid-19 vaccine to the patient.

I understand that this product has not been approved or licensed by the FDA but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019(Covid-19) for use in individuals of a certain age.

I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine. I understand the risks and benefits associated with the above vaccine and could review the Emergency Use Authorization Fact Sheet on the Covid-19 vaccine. I have elected for the patient to receive. https://www.fda.gov/media/144414/download. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that the patient must remain in the observation area for 15-30 minutes after administration. I understand that Pediatric Dream Care or their agents, at the discretion of the present medical professional, will call 9-1-1 for any medical assistance that may be needed.

I acknowledge that Pediatric Dream Care will be reporting my vaccine history to the Florida Department of Health. I acknowledge the opportunity to review the Notice of Privacy Rights at Pediatric Dream Care.

_____ _____ ____/ ____/ _____

Parent /Legal Guardian's name (print) Signature Date