Salud Pediatrics COVID-19 Vaccine Consent Form

Patient Name: _____

Patient DOB: _____

By signing below, I acknowledge that I understand the benefits and risks of the COVID-19 vaccine and consent that that the COVID19 vaccine be given to the person named above for who I am authorized to make this request.

I have been given and read the Emergency Use Authorization (EUA) for the Pfizer/Comirnaty Vaccine and have had my questions answered about the COVID-19 vaccine.

I understand the Pfizer/Comirnaty primary series requires two doses, 21 days or more apart, to be fully effective. I agree for my child to obtain the second dose.

Parent or custodial parent SIGNATURE _____

Relationship to minor _____

Date: _____/_____/_____

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