

Bronson COVID-19 Vaccine Consent Form: Minors

Patient Name:

Last: _____ First _____ Middle _____

Date of Birth: _____

Phone: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Race: ☐ African American or Black ☐ American Indian

☐ Alaskan Native ☐ Asian ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

COVID -19 Screening Questions (Circle Yes or No)

Yes No Have you had a severe or immediate allergic reaction to a vaccine, vaccine component, or medicine you got from an injection?

Yes No Have you ever had a severe allergic reaction to any substance that resulted in problems breathing, facial swelling, use of epinephrine, or a hospital visit?

Yes No Have you been given monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the last 90 days?

Yes No Are you pregnant?
If yes, have you consulted with your healthcare provider about receiving the COVID-19 vaccine? Yes No

Continued on opposite side.

To be completed by clinical staff:

Clinical Reviewer: _____ **Date & Time:** _____

Approved to receive vaccine: ☐ Yes ☐ No **Observation:** ☐ 15min ☐ 30 min

OVER →

BRONSON HEALTHCARE GROUP

Permission for Minor to receive the COVID 19 Vaccination

I give Bronson, its employees and volunteers permission to give _____ the Pfizer COVID 19 vaccine.

I understand the vaccine:

I have reviewed the COVID 19 Vaccination Consent Form.

I received and understand the "Fact Sheet for Recipients and Caregivers". [Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet for Recipients and Caregivers \(michigan.gov\)](https://www.michigan.gov/pfizer-biontech-covid-19-vaccine-eua-fact-sheet-for-recipients-and-caregivers)

I have had my vaccine questions answered.

I have advised the minor to wait for 15 minutes after getting the vaccine.

Attendance:

The vaccine may be given without a parent or guardian being present.

Billing:

The insurance company on file may be billed for the administration fee for the vaccine.

Immunization Record:

Immunizations are reported to the Michigan Care Improvement Registry (MCIR)

I can access the MCIR Fact Sheet for Parents and Patients at <https://www.mcir.org/resource/public-frequently-asked-questions/>

(Authorized Person Name Printed)

(Authorized Person Name Signature)

(Relationship to Patient)

(Phone Number)

To be completed by clinical staff:

RN/MA Sign: _____		Date&Time: _____
Vaccine	Lot Number	Site Administered
Pfizer		Right Arm Left Arm