

COVID-19 VACCINE CONSENT FOR MINORS

Patient Name _____ Date of Birth _____

First or Second Dose of Vaccine: First ☐ Second ☐

Acknowledgement: I have been provided an opportunity to review the COVID-19 Vaccine Fact Sheet for Recipients and Caregivers. I understand that I can review the Fact Sheet onsite or online (QR code below).

Pfizer-BioNTech COVID-19 vaccine fact sheet: www.fda.gov/media/144414/download

Moderna COVID-19 vaccine fact sheet: www.fda.gov/media/144638/download

Janssen/Johnson & Johnson COVID-19 vaccine fact sheet: www.fda.gov/media/146305/download



QR CODE FOR VACCINE FACTSHEETS

Additional information about COVID-19 vaccines is available at: kingcounty.gov/yourvaccine

Authorized Adult Consent: I am authorized to consent for the patient named above to receive this vaccine. I request that the vaccine be given to the patient named above. I understand that the patient should stay at the vaccine location for 15 to 30 minutes after receiving the vaccine to be monitored for potential immediate vaccine-related reactions and side effects and receive medical intervention if needed.

SIGNATURE (PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE)	PRINT NAME	DATE
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IF SIGNED BY PERSON OTHER THAN THE PATIENT, CHECK RELATIONSHIP TO PATIENT:

- | | | |
|--|--|--|
| <input type="checkbox"/> 1. Court-appointed Guardian | <input type="checkbox"/> 2. Durable Healthcare Power of Attorney | <input type="checkbox"/> 3. Spouse/registered domestic partner |
| <input type="checkbox"/> 4. Adult Child(ren) | <input type="checkbox"/> 5. Parent(s) | <input type="checkbox"/> 6. Adult Brother(s)/Sister(s) |
| <input type="checkbox"/> 7. Adult Grandchild(ren) | <input type="checkbox"/> 8. Adult Niece(s)/Nephew(s) | |
| <input type="checkbox"/> 9. Adult Aunt(s)/Uncle(s) | <input type="checkbox"/> 10. Adult Friend with executed Declaration per RCW 7.70.065 | |

FOR MINOR PATIENTS:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> 1. Guardian/legal custodian | <input type="checkbox"/> 2. Court-authorized person for child in out-of-home placement | <input type="checkbox"/> 3. Parent(s) |
| <input type="checkbox"/> 4. Holder of signed authorization from parent(s) | <input type="checkbox"/> 5. Adult representing self to be a relative responsible for the minor's health | |

OR

For Vaccine Site:

Verbal consent by _____ given by _____ to _____ on _____
Authorized Adult Name Phone/Device Staff Name Date

Minor Consent: I am a legally emancipated minor, a minor married to an adult, or have been determined a mature minor. I request that I be given the vaccine. I understand that I should stay at the vaccine location for 15 to 30 minutes after receiving the vaccine to be monitored for potential immediate vaccine-related reactions and side effects and receive medical intervention if needed.

Signature of Emancipated/Married to An Adult Minor/Mature Minor:	Printed Name:	Date:
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PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
UW Neighborhood Clinics – Valley Medical Center
University of Washington Physicians Seattle, Washington

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