COVID-19 Vaccination Consent Form 5-11 Year Olds

I have received a copy of the Emergency Use Authorization (EUA) and /or applicable Vaccine Information Fact Sheet prior to receiving my immunization and have had an opportunity to ask questions. I understand the benefits and risks of the COVID-19 vaccine as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign. I understand that RiverStone Health will provide documentation of my vaccination to the Montana State Immunization Registry called ImMTrax.

Name (please print) Birth Date Age

Address City State Zip

Signature of Parent or Guardian Date

Phone number (_____) _____-_____

Do you have allergies? **___ Yes ___ No**

If so, what are you allergic to? _____

Have you ever had a serious reaction after receiving a vaccination? **___ Yes ___ No**

Ethnicity ____ **Not** Hispanic or Latino ____ Hispanic or Latino

Race ____American Indian/AK Native ____Asian ____Native HI/Pacific Islander

____Black/African American ____White ____Unknown ____Other

Vaccine information - To be completed by Staff:

____Pfizer 1st Dose ____2nd Dose

Name/Manufacturer/Lot number _____

Body Site **____ Right Deltoid** **___Left Deltoid**

Staff signature _____ **Date**_____