COVID-19 Immunization Consent Form for Individuals Under 18 Years of Age

RECIPIENT NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month day year

ADDRESS CITY	STATE	ZIP	EMAIL

Parent/Legal Guardian (Last)	Parent/Legal Guardian (First)	(Middle Initial)

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of reviews as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known or potential benefits of the vaccine outweigh the known and potential risks.

Consent

I certify that I am the parent or legal guardian of the patient. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

On behalf of myself and dependent I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. By signing below, I hereby do consent to the Provider reporting immunization information to the State Registry.

I understand that there will be no cost for this vaccine. I understand that any monies or benefits for administering the vaccine(s) will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to copies of claims and itemized bills) to verify payment. AMI is only facilitating the delivery of vaccine to the individual and is/will not be responsible for the outcome of the vaccine, including any adverse reactions to the vaccine.

Parent/Guardian Signature	Date	Print Name	Relationship to patient