**Patient Information**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dose of Vaccine?** (check one) First Dose \_\_\_\_ Second Dose \_\_\_\_

**Full Approval:** The FDA (Food and Drug Administration) and CDC (Centers for Disease Control and Prevention) have fully approved the COVID-19 Pfizer vaccine, effective 8.30.21, and the COVID-19 Pfizer vaccine is no longer considered to be under an EUA (Emergency Use Authorization) for individuals 16 years and above. However, Seattle Children’s will follow the same procedures as when the COVID-19 Pfizer vaccine was under an EUA until further CDC official guidance is received.

**Acknowledgement:** I have been provided with the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that me/ my child 16 years to under 18 years of age is receiving. I have read or had read to me the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits, and risks of vaccination. I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I/ my child will become immune or that I/ my child will not experience side effects. I have made the decision to receive or to have my child receive the COVID-19 vaccine voluntarily and freely and I assume full responsibility for any reactions that may result. I understand that I/ my child should remain in the vaccine administration area, or an area identified by my health care provider for 15 minutes (or 30 minutes as indicated) after the vaccination to be monitored for any potential adverse reactions. I understand if I/ my child experience side effects that I should do the following: call my doctor or call 911. I request that the vaccine be given to me, or the stated person named above for whom I am authorized to make this request.

**Disclosure of Records:** I understand Seattle Children’s may be required to or may voluntarily disclose my or my child’s health information to my/ their primary care physician, insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment, or health care operations. I also understand Seattle Children’s will use and disclose my/ my child’s health information as described in Seattle Children’s Notice of Privacy Practices.

**Signature of patient to receive vaccine:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

**Signature of legal guardian/ parent authorized to consent for patient to receive vaccine:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of clinician administering vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

**Seattle Children’s Badge Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_ OR **Epic Medical Records Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Dated: 9/13/21*