# Pfizer-BioNTech COVID-19 Vaccine
## *Consent for Individuals Under 16 Years of Age*

**Section 1**: Information about the patient to receive Pfizer-BioNTech COVID-19 Vaccine

Patient Name (Last, First, Middle) Date of Birth Age

Street Address City State Zip

Phone Number (Required)

**Section 2:** Information on the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine.

Currently the U.S. Food and Drug Administration (FDA) has given full approval for the use of Pfizer-BioNTech Vaccine to prevent COVID-19 in individuals 16 years of age and older. The FDA has **not** yet approved licensure of vaccine to prevent COVID-19 in patrons 5-15 years of age. To learn more about the risks, benefits and side effects of the Pfizer-BioNTech Vaccine, read the FDA's FACT SHEET(S): 5-11 https://www.fda.gov/media/153717/download
12+ https://www.fda.gov/media/153716/download

**Section 3:** I have reviewed the FDA fact sheet information on risks and benefits of the Pfizer-BioNTech Vaccine and understand the risks and benefits. I agree that:

1. I have reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer-BioNTech Vaccine.
2. I have legal authority to consent to have the patient named above vaccinated with the Pfizer-BioNTech Vaccine.
3. I understand I am not required to accompany the patient named above to the vaccination appointment, and by giving my consent below, the patient will receive the Pfizer-BioNTech whether or not I am present at the vaccination appointment.
4. I understand that as required by state law, all immunizations will be reported to the North Carolina Immunization Registry (NCIR) as well as North Carolina COVID Vaccine Management System (CVMS). I understand this information will be treated as confidential medical information, and shall only be shared as allowed by law.

I GIVE CONSENT for the patient named at the top of this form to get vaccinated with Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form.

Name (Last, First, Middle) Relationship to Patient

Signature Date

Address **IF** different from above

Phone Number (Required) **IF** different from above