Pfizer-BioNTech COVID-19 Vaccine
Parental Consent Form

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 COVID-19 vaccine to prevent COVID-19 in individuals 16 years of age and older. The FDA has **not** yet approved licensure of the Pfizer-BioNTech COVID-19 vaccine to prevent COVID-19 in individuals 5-15 years of age. The FDA has **not** yet approved licensure of a Pfizer-BioNTech COVID-19 dose 3 for immunocompromised individuals 5+ years of age or a Pfizer-BioNTech COVID-19 booster dose in individuals 12-17 years of age. To learn more about the risks, benefits, and side effects of the Pfizer-BioNTech COVID-19 vaccine, see 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 COVID-19 vaccine and understand the risks and benefits. I agree that:

1. I have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the Pfizer-BioNTech COVID-19 vaccine.
2. I have legal authority to consent for the patient named above to receive the Pfizer-BioNTech COVID-19 vaccine.
3. 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-19 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 above to receive the Pfizer-BioNTech COVID-19 vaccine. I 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