



**Vermont Department of Health  
COVID-19 Immunization Clinic  
Consent Form**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

- I certify that I am the patient and at least 18 years of age, or the parent or legal guardian of the patient.
- I have been given a copy of the Emergency Use Authorization (EUA) for Vaccine Recipients or the Vaccine Information Statement for the COVID-19 vaccine I will receive today.
- I have read and understand the information contained in the EUA for Vaccine recipients or the Vaccine Information Statement.
- I have been given the opportunity to ask questions about the COVID 19 vaccine.
- I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to provide consent.\*

**Patient's Signature:** \_\_\_\_\_

**Date Consent Form Signed:** \_\_\_\_\_

**Parent/Legal Guardian Signature\* (if patient is under 18)** \_\_\_\_\_

\*If minor is in state custody, an authorized representative signature is required.

**Parent/Legal Guardian's Name (please print):** \_\_\_\_\_

**Parent/Legal Guardian's Daytime Phone Number\*\*:** \_\_\_\_\_

\*\*If parent/legal guardian will not be present at the clinic.