The University of Texas at Austin School of Nursing
CONSENT FOR THE IMMUNIZATION OF A MINOR

(Only for COVID-19 vaccine for individuals 17 years old or less)

Patient Name (Please Print): _____

Patient Date of Birth: _____

Individual consenting to vaccination of PATIENT (CONSENTOR) (Please Print):

_____

SECTION 1

1. Is the CONSENTOR: a. A parent or guardian of PATIENT	Yes □	No □
2. Is the CONSENTOR: a. a grandparent of PATIENT; b. an adult brother or sister of PATIENT; c. an adult aunt or uncle of PATIENT; d. a stepparent of PATIENT; e. an adult who has actual care, control, and possession of PATIENT and has written authorization to consent for PATIENT from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for PATIENT; f. an adult having actual care, control, and possession of PATIENT under an order of a juvenile court or by commitment by a juvenile court to the care of an agency of the state or county; or g. an adult having actual care, control, and possession of PATIENT as PATIENT's primary caregiver? If NO, please have a person identified in Question 1 or 2 complete and sign this form.	Yes □	No □

Section 2

Pursuant to the National Childhood Vaccine Injury Act of 1986 (42 U.S.C. Section 300aa-1 et seq.) the United States established the National Vaccine Injury Compensation Program (VICP) to allow recovery of some unreimbursed expenses for certain injuries arising out of the administration of certain vaccines. In order to obtain reimbursement for an injury you must file a claim with the VICP. Information about the VICP is available at https://www.hrsa.gov/vaccine-compensation/index.html and you may call 202-357-6400 to obtain sample documents for filing a claim.

Section 3

By signing this form, CONSENTOR acknowledges the following:

- I voluntarily consent to PATIENT receiving the COVID-19 vaccination at a Del Valle ISD campus administered by a staff member of UT Austin after carefully considering the risks and benefits;
- I received information about PATIENT's possible side effects of the COVID-19 vaccine, as presented in the Emergency Use Authorization information pamphlet provided to me;
- I received information about the known risks and side effects, the possibility of unknown adverse reactions, and the need for continued masking/social distancing after PATIENT receives the COVID-19 vaccination;
- UT Austin w i l l provide me with a completed COVID-19 vaccination card for PATIENT and access to an electronic vaccination record;
- I understand that the COVID-19 vaccinations given at a Del Valle ISD campus will be tracked and reported to ImmTrac, and as otherwise required by the local, state and federal government.

_____ _____

Signature of CONSENTOR Date

For Administrative Use Only: FOR ADMINISTRATIVE USE ONLY

_____ _____

Signature of person obtaining phone consent (if applicable) Date

_____

Date of Immunization

_____

Clinic Name

UT School of Nursing

MOBILE VACCINE LOG *(please write legibly | all information is required)*

DVISD School: _____ Grade _____ Homeroom teacher _____

NAME:

DATE OF BIRTH:

RACE:

ETHNICITY:

ADDRESS:

PHONE/EMAIL:

CITY/STATE/ZIP:

GENDER:

Vaccinator Use Only:	
Arm: right left	Administered By:
Lot #:	Vaccine Brand: Pfizer J&J Moderna
Consent to Vaccine: yes no	Patient Dose: 1 2 3 B single dose

Registration Use Only: Initial Date: ____/___/__

Pfizer/Moderna Follow Up Date: ___/___/___

UT School of Nursing

REGISTRO DE VACUNAS MOVIL (*por favor escriba de manera legible| toda información es requerida)*

Escuela DVISD: _____ Grado _____

Maestro _____

NOMBRE:

FECHA DE NACIMIENTO:

RAZA:

ETNICIDAD:

DIRECCIÓN:

TELÉFONO/CORREO ELECTRÓNICO:

CIUDAD/ESTADO/CÓDIGO POSTAL:

GENERO:

Solo para uso del vacunador:	
Brazo: derecho izquierdo	Administrado por:
Lote #:	Marca de vacuna: Pfizer J&J Moderna
Consentimiento para la vacuna: si no	Dosis del paciente: 1 2 3 B dosis única

Solo para uso de registro: Fecha Inicial: ___/___/__

Pfizer/Moderna Fecha de seguimiento: ___/___/___