UPMC | CHILDREN'S HOSPITAL OF PITTSBURGH

Parental Consent Form
Pfizer COVID-19 Vaccine

Patient Name: _____ **DOB**: _____

Parent/Guardian Name: _____

Parent Telephone #: ( ) _____

Clinic Location: _____

I affirm that I wish for my child to receive the Pfizer COVID-19 vaccine. As a condition of my child receiving this vaccine, I further affirm the following:

- I am the parent or legal guardian of the minor child listed above.
- I consent to my child receiving the Pfizer COVID-19 vaccine.
- I consent to receiving post-vaccination surveys regarding side effects.
- I understand that information related to my child's receipt of the vaccine or participation in post-vaccine surveys will be reported as a requirement of the PA Statewide Immunization Information System (PA-SIIS).

I have read and understand the foregoing statements and I sign this consent freely, knowingly, and voluntarily.

_____ _____
Parent or Legal Guardian Signature Date

***Parent not present – verbal consent obtained by phone (please verify Parent name and contact information above)**

_____ _____
Name of staff obtaining consent Date

Comments: