LOUISVILLE METRO PUBLIC HEALTH AND WELLNESS
COVID-19 VACCINATION CONSENT FORM FOR MINORS

Patient Demographics

Patient name: ___________________________________

Patient birth date: ______ / ______ / ______

Parent/Guardian

Name of parent/guardian: ___________________________________

Parent/guardian telephone number: ___________________________________

Informed Consent

By signing this form, I verify that:
1. I am the legal guardian for the above named minor.
2. I understand that this vaccine is being given under an Emergency Use Authorization (EUA) and have been provided with information about what this means.
3. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request.
4. The information I have provided regarding my health is correct.
5. I agree to wait after vaccination for a period of at least fifteen (15) minutes of observation.
6. If I have a history of anaphylaxis to polyethylene glycol, or to any vaccine; or if I am currently pregnant; I agree to wait after vaccination for a period of at least thirty (30) minutes of observation.
7. I understand that this vaccine is part of a two-shot series, and I agree to return after a period of twenty- eight (28) days to receive the second dose.
8. I have been provided with information regarding side effects from this vaccine.
9. The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature, and title of the person who gave the vaccine, and the address where the vaccine was given.
10. I request that payment of authorized medical insurance benefits be made to Louisville Metro Public Health and Wellness on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services.
11. I wish for the SARS CoV-2 (COVID-19) vaccine to be administered to the above-named minor.
12. I acknowledge the HIPAA Privacy Notice for the Louisville Metro Department of Public Health and Wellness has been presented to me.

Signature of parent or legal guardian: ________________________________

Date: ______ / ______ / ______

OFFICE USE ONLY

Name of vaccine administrator: ___________________________________

Name of second witness: ___________________________________