Public Health
Prevent. Promote. Protect.
Muskegon County

COVID-19 VACCINATION AUTHORIZATION
FOR A MINOR

Please Print **Client #** _____ **Date:** _____

Minor's Legal Name: _____
Last *First* *Middle*

MUST BE AT LEAST 12
Minor's Birth Date: _____ / _____ / _____ **AGE** _____
Month / Day / Year

Other Name Used: _____

Minor's Gender: ☐ Male ☐ Female **Race/Ethnicity:** ☐ Native Amer. ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other

Address: _____
Street *City* *Zip*

Primary Telephone: (_____) _____

County of Residence: ☐ Muskegon ☐ Other: _____

Please Print:

Parent/Legal Guardian's Name:

_____
Last *First* *Middle*

Parent's Birth Date: _____ / _____ / _____ **AGE** _____
Month / Day / Year

Maiden/Other Name Used: _____

The following questions will help us determine if there is any reason the minor should not receive the COVID-19 vaccine today. If you answer "yes" to any questions, it does not necessarily mean the minor should not be vaccinated. It just means additional questions may be asked. If a question if not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Is the minor feeling sick today?			
2. Have they ever received a dose of COVID-19 vaccine? • If yes, what was the date and which vaccine product? Date: _____ ☐ BioNTech (Pfizer) ☐ Another Product_____			
3. Have they ever had an allergic reaction to			
• A component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine			
• A vaccine or injectable therapy that contains multiple components.			
4. Have they ever had an allergic reaction to another vaccine or an injectable medication?			
5. Have they ever had a severe allergic reaction to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental or oral medication allergies?			
6. Have they received any vaccinations in the past 14 days?			
7. Have they ever had a positive test for COVID-19 or has a doctor ever told you that they had COVID-19?			
8. Have they received passive antibody therapy as treatment for COVID-19?			
9. Do they have a weakened immune system caused by something such as cancer, leukemia, AIDS, any other immune system problem or do they take immunosuppressive drugs or therapies?			
10. Do they have a bleeding disorder or are you taking a blood thinner?			
11. Are they pregnant or breastfeeding?			
12. Do they have dermal fillers?			
13. Have they ever fainted in association with an injection?			

To Be Completed By Parent/Legal Guardian	INITIAL
1. I certify that I am the parent or legal guardian of the minor listed above.	
2. I certify that they are at least 12 years of age.	
3. I acknowledge that we received a copy of the EUA Fact Sheet for Recipients and Caregivers.	
4. I confirm that I have read the above Fact Sheet.	
5. I understand, that they should receive a 2nd dose of the vaccine and will do so when scheduled.	
6. I understand that the COVID-19 vaccine is available under an emergency access mechanism called an EUA and has not undergone the same type of review of FDA approved or cleared products.	
7. I have been given the opportunity to ask questions before I sign.	
8. I authorize the public health official to administer the COVID-19 Vaccination.	

I, the undersigned, have been informed about the purpose, procedures and possible benefits and risks of the minor above receiving the vaccine. I have been given the opportunity to ask questions before I sign and I have been told that I can ask other questions at any time. I confirm that I am the parent or legal guardian of the minor listed above and voluntarily agree to have them receive the COVID-19 vaccination.

Client/Guardian's Signature: _____ **Date:** _____

Office Use Only

Vaccination Administration Information			
Manufacturer:	☐ Pfizer ☐ Other: _____		Time Administered:
Lot Number:		Site: ☐ L ☐ R	Route:
Name (Print):			
Title:			
Signature:			