



5 to 11 y/o

Contact information – person being vaccinated

Last Name: _____ First Name: _____

D.O.B: ____/____/____ Age: _____ Contact #: (____) _____ - _____

Address: _____

Check here if person getting the vaccine does not have insurance.

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy/ID/member #: _____ Group #: _____

Policy holder, if different from the person getting vaccinated:

Name: _____ D.O.B: ____/____/____

AGREEMENT

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the **PFIZER** Covid-19 vaccine.
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the Pfizer COVID-19 vaccine for myself or for the person named above.

Signature: _____ Date: ____/____/____
(of patient or parent/guardian)