





UPMC
Parental Consent Form
COVID-19 Vaccine

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent Telephone #: ( ) \_\_\_\_\_

Clinic Location: \_\_\_\_\_

I affirm that I wish for my child to receive the 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 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

For Staff Use Only

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

Name of staff obtaining consent

Date

Comments: