



**Parental Consent Form  
Pfizer COVID-19 Vaccine**

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

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 statement and I sign this consent freely, knowingly, and voluntarily.

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date

**\*Note: Parent must be present with child receiving the vaccination.**