CONSENT FOR THE IMMUNIZATION OF A MINOR

(Only for COVID-19 vaccine for individuals 17 years old or less)

Patient Name (Please Print): _____

Patient Date of Birth: _____

Individual consenting to vaccination of PATIENT (CONSENTOR) (Please Print): _____

SECTION 1

1. Is the CONSENTOR: a. A parent or guardian of PATIENT	Yes □	No □
2. Is the CONSENTOR: a. a grandparent of PATIENT; b. an adult brother or sister of PATIENT; c. an adult aunt or uncle of PATIENT; d. a stepparent of PATIENT; e. an adult who has actual care, control, and possession of PATIENT and has written authorization to consent for PATIENT from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for PATIENT; f. an adult having actual care, control, and possession of PATIENT under an order of a juvenile court or by commitment by a juvenile court to the care of an agency of the state or county; or g. an adult having actual care, control, and possession of PATIENT as PATIENT's primary caregiver? If NO, please have a person identified in Question 1 or 2 complete and sign this form.	Yes □	No □

Section 2

Pursuant to the National Childhood Vaccine Injury Act of 1986 (42 U.S.C. Section 300aa-1 et seq.) the United States established the National Vaccine Injury Compensation Program (VICP) to allow recovery of some unreimbursed expenses for certain injuries arising out of the administration of certain vaccines. In order to obtain reimbursement for an injury you must file a claim with the VICP. Information about theVICP is available at https://www.hrsa.gov/vaccine-compensation/index.html and you may call 202-357-6400 to obtain sample documents for filing a claim.

Section 3

By signing this form, CONSENTOR acknowledges the following:

- I voluntarily consent to PATIENT receiving the COVID-19 vaccination at UT Austin after carefully considering the risks and benefits;
- I received information about PATIENT's possible side effects of the COVID-19 vaccine, as presented in the Emergency UseAuthorization information pamphlet provided to me;
- I received information about the known risks and side effects, the possibility of unknown adverse reactions, and the need for continued masking/social distancing after PATIENT receives the COVID-19 vaccination;
- UT Austin will provide me with a completed COVID-19 vaccination card for PATIENT and access to an electronic vaccination record;
- I understand that the COVID-19 vaccinations given at UT Austin will be tracked and reported to ImmTrac, and as otherwise required by the local, state and federal government.

_____ _____
Signature of CONSENTOR Date

FOR ADMINISTRATIVE USE ONLY

_____ _____
Signature of person obtaining phone consent (if applicable) Date

_____
Date of Immunization

_____
Clinic Name