

CONSENT FOR THE IMMUNIZATION OF A MINOR

(Only for COVID-19 vaccine administered to minor 16 years of age or older)

Individual for whom vaccination is being requested (MINOR):

_____ (PATIENT)

Please Print

Date of Birth: _____

Date vaccination treatment to begin: _____

(Date must be completed before signing or CONSENTOR must be present for vaccination)

Individual consenting to vaccination of PATIENT:

_____ (CONSENTOR)

Please Print

CONSENTOR's relationship to PATIENT: _____

If CONSENTOR is not a parent or managing conservator, PATIENT's parent(s) and any managing conservator are:

SECTION 1

<p>1. Is the CONSENTOR either:</p> <ul style="list-style-type: none"> a. A guardian of PATIENT; or b. A person authorized by the law of another state to consent for PATIENT? <p>If YES, please skip to Question 4. If NO, please continue to Question 2.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>2. Is a person who is identified in Question 1 available to sign this form as CONSENTOR?</p> <p>If YES, please have that person complete and sign a copy of this form. If NO, please continue to Question 3.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>3. Is the CONSENTOR any of:</p> <ul style="list-style-type: none"> 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? <p>If YES, please continue to Question 4. If NO, please have a person identified in Question 1 or 3 complete and sign this form.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
<p>4. Does CONSENTOR know that a parent, managing conservator, guardian of PATIENT, or other person who under the law of another state or a court order may consent for Patient:</p> <ul style="list-style-type: none"> a. has expressly refused to give consent to the immunization; b. has been told not to consent for PATIENT; or c. has withdrawn a prior written authorization for CONSENTOR to consent? <p>If YES, please have a person identified in Question 1 complete and sign this form. If NO, please continue to Section 2.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

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 the VICP 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;
- UT Austin advised me to consult with PATIENT's medical provider to discuss PATIENT's personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination;
- I received information about PATIENT's possible side effects of the COVID-19 vaccine, as presented in the Emergency Use Authorization 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 provided me with a completed COVID-19 vaccination card for PATIENT and/or access to an electronic vaccination record;
- I understand that if PATIENT experiences adverse side effects after receiving the COVID-19 vaccination, I will contact PATIENT's primary care physician or UT Austin immediately;
- 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