



Fort Bend County Health & Human Services

Full Name of Patient _____

I consent and agree for my minor child to receive a vaccination/s for COVID-19 from Fort Bend County.

The vaccination will be for the [please initial] _____ Pfizer vaccine: TWO doses.
You will be informed of when the second dose is available.

I declare that my child is 12 years of age or older and that my child:

1. Has not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
3. Has have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.

I understand that if my child has any of the above conditions, my child could be at increased risk of having a negative reaction or problem from the vaccine. I further declare that if I my child has any of the following conditions, I have had the opportunity to speak with my child's primary care provider and am making an informed decision to have my child receive the vaccine:

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I or my child will receive the first and second part of the vaccine series.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Fort Bend County. In consideration of my minor child's receipt of the COVID vaccine, I agree as Parent/Guardian of the below named minor child to release, indemnify and hold harmless Fort Bend County, its employees, officers, volunteers and agents (collectively "the County") from and against any and all claims made by or concerning the minor child arising out of or caused BY INCLUDING BUT NOT LIMITED TO LOSS, INJURY OR DEATH CAUSED OR CONTRIBUTED TO BY THE NEGLIGENCE OR GROSS NEGLIGENCE OF FORT BEND COUNTY AND/OR ITS EMPLOYEES, OFFICERS, VOLUNTEERS AND AGENTS.



Fort Bend County Health & Human Services

I have read and understood **Pfizer EUA** by the FDA regarding the COVID-19 Vaccination. I further understand and agree that Fort Bend County is required to submit COVID-19 vaccine administration data to the Texas Immunization Information System and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

In the event that my child should require medical treatment and I cannot be contacted immediately, or if contacting me is not feasible because of an emergency, I hereby give my consent to such treatment. I also agree that any treatment provided is my financial responsibility.

I understand and agree to all of the above and I hereby give my consent to Fort Bend County to give my child a COVID-19 vaccine. I acknowledge receipt of Fort Bend County's Notice of Privacy Practices. I am the Parent/Guardian of the below mentioned participant who is a minor child (under 18 Years old). By signing as Parent and Guardian, I agree on behalf of the Participant, to the entirety of the statements above.

Signature of Individual/Guardian: _____ Date: _____

Printed Name _____

Printed Name of Minor Child (if any) _____