



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

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

**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 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:**