



**Vermont Department of Health
COVID-19 Immunization Clinic
Consent Form**

Patient's Name: _____ **DOB:** _____

- I certify that I am the patient and at least 18 years of age, or the parent or legal guardian of the patient.
- I have been given a copy of the Emergency Use Authorization (EUA) for Vaccine Recipients or the Vaccine Information Statement for the COVID-19 vaccine I will receive today.
- I have read and understand the information contained in the EUA for Vaccine recipients or the Vaccine Information Statement.
- I have been given the opportunity to ask questions about the COVID 19 vaccine.
- I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to provide consent.*

Patient's Signature: _____

Date Consent Form Signed: _____

Parent/Legal Guardian Signature* (if patient is under 18) _____

*If minor is in state custody, an authorized representative signature is required.

Parent/Legal Guardian's Name (please print): _____

Parent/Legal Guardian's Daytime Phone Number:** _____

**If parent/legal guardian will not be present at the clinic.