## **STUDENT Vaccination Consent Form**

(PLEASE PRINT LEGIBLY IN CAPITAL LETTERS USING BLACK OR BLUE INK)

	M M / D D / Y Y
Student's Last Name Student's First Name M.I. Student's Date of Birth	
Student's Address	
	Student's Gender
City	tate Zip Code
Parent/Guardian Home Phone Parent/Guardian Da	ytime Phone Parent/Guardian Cell Phone
( )	( )
School Name	Grade (Select one "●") (K) (1) (2) (3) (4) (5) (6) (7)
	K 1 2 3 4 5 6 7
	8 9 10 11 12 8 9 10 11 12
Student's Doctor's Name (Last)	(First)
Students Boctors Name (Lusty	(1130)
I have reviewed and completed the Prevaccination Checklist for COVID-19 Vaccines for my child.	
I have received and read the most current FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 5 TO 11 YEARS OF AGE, OR 12 YEARS OF AGE AND OLDER, whichever applies to my child. I understand the risks and benefits, and give consent for my child to receive the	
Pfizer COVID-19 vaccine. In addition, I have received information regarding the Hawaii Immunization Registry (see attached).	
I affirm that I am the parent or legal guardian of the child named at the top of this form.	
Parent or Legal Guardian Name (Please Print)  Parent or I	Legal Guardian Signature Date (MM / DD / YY)