Informed Consent — COVID-19 Initial Vaccination for under 16 or Booster for 12-17

Your child is being offered an Pfizer-BioNTech COVID-19 initial vaccine or booster to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2 (hereinafter, the "COVID-19 Vaccine").


The COVID-19 Vaccine may prevent your child from getting COVID-19. The U.S. Food and Drug Administration (FDA) has not approved a vaccine to prevent COVID-19 in children under 16. However, after careful review, the FDA provided emergency authorization to the use of the COVID-19 Vaccine to prevent COVID-19 in children under 16 (see link above). The COVID-19 Vaccine primary series is administered by a licensed health provider under contract with the Commonwealth of Massachusetts (or its designee) as a 2-dose series, 3 weeks apart, into the muscle; in some patients, a 3rd dose may be included in this initial series, if their provider is concerned that their immune system may not respond adequately to the standard 2-dose series. A single booster dose of the COVID-19 Vaccine can be administered in children 12-17 years of age after completion of a primary series of the vaccine (see link above for current guidelines).

The COVID-19 vaccine may not protect everyone. Side effects that have been reported with the COVID-19 Vaccine include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of your face and throat, a fast heartbeat, and/or a bad rash all over your body.

In signing this form, I agree that:

1. I have reviewed this informed consent, as well as the “Fact Sheet for Recipients and Caregivers,” which includes more detailed information about the potential risks and benefits of the COVID-19 Vaccine.
2. I have the legal authority to consent to have my child age 5-15 vaccinated with the COVID-19 Vaccine.
3. I have the legal authority to consent to have my child age 12-17 receive the COVID-19 Booster.
4. I understand that while precautions will be taken for my child’s safety, neither Mass General Brigham nor any of their respective trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to me (or my child), as a result of agreeing to receive the COVID-19 Vaccine or Booster.
5. I understand that agreeing to receive the COVID-19 Vaccine or Booster is optional, and that I can refuse to give this authorization.
6. I give permission for my insurance company to be billed for the costs of administering the COVID-19 Vaccine. The government is paying for the COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization.
7. I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Factsheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family’s data being shared with other providers in the MIIS.

I have reviewed the information referenced above, including information regarding the possible benefits and risks of the COVID-19 Vaccine. I may receive a copy of this consent upon request. I have been given the opportunity to ask questions before I sign this document, and I have been told that I can ask additional questions at any time.

I consent to having my child receive the COVID-19 Vaccine or Booster.

| Signature of Patient  
| (or Parent/Guardian, if applicable): |
| Printed Name of Parent/Guardian  
| (if applicable): |
| Relationship to Patient  
| (if applicable): |
| Date: |