Public Health
Prevent. Promote. Protect.
Muskegon County

COVID-19 VACCINATION AUTHORIZATION
FOR A MINOR

Please Print	**Client # ____________ Date: ___________**
Minor's Legal Name: ______________________________________ *Last* *First* *Middle*	
MUST BE AT LEAST 5 YEARS OLD **Minor's Birth Date:** ______ / _____ / _______ **AGE** _____ *Month / Day / Year*	**Other Name Used:** ________________________
Minor's Gender: ☐ Male ☐ Female **Race/Ethnicity:** ☐ Native Amer. ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other	
Address: ______________________________________ *Street* *City* *Zip*	
Primary Telephone: (_______) ___________________	**County of Residence:** ☐ Muskegon ☐ Other: ______________
Please Print:	
Parent/Legal Guardian's Name: ______________________________________ *Last* *First* *Middle*	

The following questions will help us determine if there is any reason the minor should not receive the COVID-19 vaccine today. If you answer "yes" to any questions, it does not necessarily mean the minor should not be vaccinated. It just means additional questions may be asked. If a question if not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Is the minor feeling sick today?			
2. Has the minor ever received a dose of COVID-19 vaccine?			
• Has the minor received a complete COVID-19 vaccine series (i.e. 2 doses)?			
• If yes, did you bring the vaccination record card or other documentation?			
3. Has the minor received any other vaccines in the last 30 days?			
4. Has the minor ever had an allergic reaction to;			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives			
○ Polysorbate, which is found in some vaccines, film coated tables and intravenous steroids			
• A previous dose of COVID-19 vaccine			
5. Has the minor ever had an allergic reaction to another vaccine or an injectable medication?			

6. Check all that apply to the minor:
☐ A male between the ages of 12 and 29 years old
☐ Have a history of myocarditis or pericarditis
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a weakened immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Currently pregnant or breastfeeding
☐ History of Guillain-Barré Syndrome (GBS)

To Be Completed By Parent/Legal Guardian	**INITIAL**
1. I certify that I am the parent or legal guardian of the minor listed above.	
2. I certify that the minor is at least 5 years of age.	
3. I acknowledge that we received a copy of the Fact Sheet for Recipients and Caregivers.	
4. I confirm that I have read the above Fact Sheet.	
5. I understand, the minor should receive an additional dose of the vaccine and will do so when scheduled	
6. I authorize the public health official to administer the COVID-19 Vaccination.	

I, the undersigned, have been informed about the purpose, procedures and possible benefits and risks of the minor above receiving the vaccine. I have been given the opportunity to ask questions before I sign and I have been told that I can ask other questions at any time. I confirm that I am the parent or legal guardian of the minor listed above and voluntarily agree to have them receive the COVID-19 vaccination.

Client/Guardian's Signature: ______________________________ **Date:** __________

Office Use Only

Vaccination Administration Information				
Manufacturer:	☐ Pfizer	☐ Other: __________		Time Administered:
Lot Number:			Site: ☐ L☐ R	Route:
Name (Print):				
Title:				
Signature:				