Community Organized Relief Effort

Minor Consent Form for Pfizer COVID-19 Vaccine

****Please complete the registration process at http://apsvax.coreresponse.org/ and then fill out the form below.** CONFIRMATION #:______________________**

Patient Information

Person receiving the vaccine:

First Name:*____________________________ Last Name:*_________________________________

Date of Birth(MM-DD-YY)*:______________________________

Is the person receiving the vaccine under 18 years of age?* Yes_____ No________

Is the person receiving the vaccine 12 years of age or older?* Yes_____ No________

Primary Mobile/Cell Phone Number:___________________________________

Please provide Parent/Guardian Information.

Name of Parent/Guardian:

First Name:*____________________________ Last Name:*_________________________________

Parent/Guardian Phone Number:*_______________________________________

_______________________________ _________________________________

Email* Relationship to Patient*

Home Address:

____

Street Name (Suite, Apt, Unit #:)*

____

City, State, Zip Code*

Community Organized Relief Effort

COVID-19 Vaccination Consent and Release Form

I hereby give consent to allow Curogram Inc. to administer a COVID-19 vaccination to me or the minor for whom I am legal guardian, and hereby release, indemnify, and hold harmless Curogram and CORE Community Organized Relief Effort (“CORE”), their agents, officers, directors, assigns, contractors, successors, and personnel from any liability that may arise out of their acts and omissions. I understand that I may ask questions about the vaccination or my care, or refuse treatment at this time, and that I am voluntarily proceeding.

The COVID-19 vaccine will reduce the risk of suffering from the new type of Coronavirus disease known as COVID-19. Please be aware that the vaccine is not completely effective like all other medicines. It can take a few weeks for your body to build up protection from the vaccine. There is always a chance to get infected by Coronavirus even with the vaccine; however, the vaccine lessens the severity of any infection. Two doses will reduce the chance of being seriously ill and reduce the risk of death due to Coronavirus. You still need to follow the health instructions in your workplace and in public areas, such as wearing a mask and keeping a distance from others after you receive the COVID-19 vaccine. The vaccine has some side effects as the other vaccines/medicines, but not everyone gets them. The most likely side effects that you may experience from the vaccine: Fever, Pain at the injection site, Redness and hardness of the skin at the injection site, Headache, Muscle aches or pain, Joint aches or pain, Fatigue (tiredness), Nausea/vomiting, Chills, Underarm gland swelling on the side of vaccination. If you think you are experiencing any side effects, please remain calm and see your doctor immediately. If you are currently pregnant or planning to get pregnant or your partner is planning to get pregnant; please see your doctor before getting vaccinated.

______________________________________ ____________________

Signature of Parent/Guardian* Date Signed*

Community Organized
Relief Effort

Authorization for Vaccination of Minors

I, ___________________________* (Parent/Guardian Name):

Knowingly and willingly consent to have my child receive the COVID-19 vaccination with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 Pandemic;

Confirm that my child is 12 years of age or older, as the vaccine is not yet approved for anyone younger than 12;

Have received, read and understand the Emergency Use Authorization Fact Sheet and/or Vaccine Information Statement for the vaccine being received;

Have received and signed the Curogram HIPAA Authorization allowing for the release of my minor's vaccine record, including vaccine status;

Have had the opportunity to discuss any medical concerns with my healthcare provider or a healthcare provider at the time of my vaccination and my questions were answered to my satisfaction;

Understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result;

Understand that my minor should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions;

Understand that if my minor have experienced previous anaphylactic reactions I should stay for 30 minutes after the vaccination to be monitored for any potential adverse reaction;

Understand that if my minor experience side effects that I should do the following:

- Contact doctor,
- Call 911.

PLEASE ASK QUESTIONS BEFORE RECEIVING THE COVID-19 VACCINE.

I understand the risks of this vaccine and ask that this vaccine be given to the person named above for whom I am authorized to make this request.

______________________________________ ________________________

Printed Name of Parent/Guardian* Relationship to Patient*

____ ________________________

Signature of Parent/Guardian* Date Signed*

Community Organized Relief Effort

HIPAA Authorization For Disclosure of COVID-19 Vaccination Records

I hereby voluntarily authorize the disclosure of my COVID-19 vaccination records, including vaccination status, provided by CORE Community Organized Relief Effort (“CORE”) through Curogram Inc. (“Curogram”), to:

- Me via email, even though email is not a completely secure means of communication.
- Me via SMS, even though SMS is not a completely secure means of communication.
- CORE
- Curogram

I also understand and agree to the following:

The purpose for which my COVID-19 vaccination records will be disclosed to the above parties is public health activities and purposes.

I may refuse to provide this authorization.

I may revoke this authorization at any time in writing emailed to Curogram at records@curogram.com, except to the extent that action has been taken in reliance on this authorization.

If this authorization has not been revoked, it will terminate 1 year from the date of effectiveness below.

I have a right to request and receive a copy of this authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the HIPAA Privacy Rule.

Any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and any redisclosure may not be subject to HIPAA.

______________________________________	____________________
Signature of Parent/Guardian*	Date Signed*