

Patient Minor Consent Form

Patient information

_____ First name	_____ Last name	
_____ Suffix (optional)	_____ Date of birth (MM/DD/YYYY)	_____ Age

Minor consent

I declare that I am (must check one):

- The parent of the minor patient.**
- The legal guardian of the named minor patient.**
- An emancipated minor at least 16 years of age.**
- A person with authority to make healthcare decisions on behalf of the minor patient.**
Describe legal relationship here: _____

I attest to the following

All boxes must be checked for the minor to be vaccinated:

- I have read and understand the Vaccine Information Statement(s) for the requested vaccine(s) and understand the risks and benefits. (VIS: <https://www.immunize.org/vaccines/vis/about-vis/>)
- I GIVE CONSENT for the minor patient to receive the vaccine(s). [If you do NOT give consent, do not complete this form.]
- I understand that by providing my voluntary consent, the minor patient can receive the vaccine(s) with or without a parent or guardian being physically present at the vaccination appointment.
- I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine(s).
- I certify that, to the best of my knowledge, the information submitted in this application is true and accurate. I understand that all immunizations will be reported to the California Immunization Registries (CAIR2 or RIDE). My Turn will put information about the patient's vaccination into CAIR2 as required by California Health and Safety Code 120440. This information can be accessed by licensed health care providers and public health departments.
- CAIR2: <https://www.cdph.ca.gov/Programs/CID/DCDC/CAIR/Pages/CAIR-updates-about.aspx>
 - RIDE: <https://www.myhealthyfutures.org>

Parent/guardian information

_____ Please write your full name	
_____ Email address (optional)	_____ Mobile number
_____ Address (Street number & name, City, State, Zip code)	

By signing my name and today's date in the boxes below, I am providing consent for the minor patient to receive the requested vaccine(s) and certify that (1) I am authorized to provide this consent and (2) all of the information I have provided on this form is true and correct to the best of my knowledge.

_____ Parent/guardian signature	_____ Date signed (MM/DD/YYYY)
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