For Individuals Under 18 years of Age/Menores de 18 años

School *(Escuela)*:
☐ Crenshaw HS
☐ Dorsey HS
☐ Lennox
☐ Other: _______________

COVID -19 VACCINE CONSENT FORM

Student's Information

Name: Last		First		Middle
Address: Street		City	State	Zip Code
Date of Birth: mm / dd / yyyy	Sex: ☐ Female ☐ Male			
Parent/Guardian:	Telephone Number:	Home: ( ) -		Cell: ( ) -

I/we have read and understand the services offered at the schools. I /we understand further that the services authorized by my/our signature on this form are simple, common or routine health care services, and treatment will be limited to:

1. Diagnosis and treatment of minor and acute illnesses
2. Physical examinations (general, sports, pre-employment)
3. Assistance with asthma, diabetes and other chronic illnesses
4. Treatment of acne and other skin problems
5. **Immunizations including COVID-19 Vaccine**
6. Vision and hearing screening
7. Laboratory Services
8. Nutrition and weight control programs
9. First aid for minor injuries
10. Limited prescriptive and over the counter items
11. Referrals for health care services, which cannot be provided at the T.H.E. Health and Wellness Centers Mobile Clinic.

____ I have read the Fact Sheet for Recipients and Caregivers: Emergency Use Authorization (EUA) of the Pfizer-BioNtech COVID-19 Vaccine to Prevent COVID-19 in Individuals **under 18 Years of Age.**

I understand that this consent only applies to services provided at the school or another T.H.E. Health and Wellness Centers site which is a result of a referral made by the school based staff and does not allow any other private or public facility. I hereby authorize a provider and other professional clinic staff to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive the above services offered at the school. I/We understand that under California State law, minors are legally able to consent for certain services without parental permission. All third party payment sources will be billed as applicable. Grant funds will be used to support services rendered to students without insurance or Medi-Cal. If my child is covered by any type of health insurance, I will provide insurance information indicated on the attached form. Medical records will be kept in a confidential manner; however, I /We acknowledge that T.H.E. Health and Wellness Centers may release information regarding treatment to third-party payers such as Medi-Cal or insurance companies for the purpose of billing. I/We also understand that public information such as immunization history or illness of public health hazard and/or any other medical information may be shared with the school nurse, school physician or Public Health Department to protect the health of other students according to the California Health and Safety Code. I understand that the T.H.E. Health and Wellness Centers privacy policy is published in the clinic's policies and procedures manuals. I/We understand that only immunization records will be shared between the school nurse and T.H.E. Health and Wellness Centers in order to maintain updated student health records as required by the Los Angeles Unified School District. **I understand that this consent may be revoked, restricted or revisited at any time in writing by me.**

Signature needed on other side/ Se necesita su firma en el otro lado

I understand that as required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry **(CAIR2)**. I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health. It shall be treated as confidential medical information and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by submitting the Request to Lock My CAIR Record form at: *https://cairforms.cairweb.org/SharingRequestForm/SharingRequestForm?SharingType=1&Language=En*.

I GIVE CONSENT for the child named at the top of this form to get vaccinated with the Pfizer-BioNTech COVID-19 Vaccine and have reviewed and agree to the information included in this form

Signature of Parent/Guardian/Conservator: ______________________________ Date: ______________

Print Name: ____________________________________ Relationship to student: ______________

Student's Signature: ______________________________ Date: __________________________

Verified Signature: _____________________________ Print: __________________________