



Cabinet for Health and Family Services

COVID-19 Vaccination Consent for Individuals Under 18 Years of Age

Information about the person who will receive the COVID-19 Vaccine:

Name of child:		Date of birth:	
Type of Custody:			
<input type="checkbox"/> Emergency custody	Date:	<input type="checkbox"/> Temporary custody	Date:
<input type="checkbox"/> Commitment	Date:	<input type="checkbox"/> Voluntary commitment	Date:

This document verifies that _____ (name of child) is in the custody or commitment of the Kentucky Department for Community Based Services (DCBS).

I, _____ (name of parent/caretaker), understand, consent, and agree that the above-named child, of whom I am the parent/caretaker, be vaccinated/immunized against COVID-19. I hereby authorize the Cabinet for Health and Family Services ("CHFS") to provide medical consent for the above-named child to receive a vaccination/immunization against COVID-19. I further authorize the foster parent(s) or private child-caring or placing-agency representative to provide medical consent for the above-named child to receive a COVID-19 vaccination/immunization in the event a CHFS representative is unavailable. I hereby by waive and relinquish any objection to the administration of the COVID-19 vaccination to the above-named child on the grounds of opposition to medical vaccination/immunization or religious belief.

The Pfizer-BioNTech COVID-19 Vaccine "Fact Sheet for Recipients and Caregivers" is available at <https://www.fda.gov/media/144414/download>. I understand that some side effects have been associated with the Pfizer-BioNTech COVID-19 Vaccine including injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, swollen lymph nodes, and allergic reactions.

Printed Name of Parent

Parent Signature

Date