Town of New Milford
Department of Health
10 Main Street • New Milford, CT 06776
Tel: (860) 355-6035 • Fax: (203) 796-1596

Unaccompanied Minor Form
Authorization to Consent for Treatment of Minors

Date:___________________

SECTION A: PATIENT DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name:	________________	Last Name:	________________
Date of Birth:	_____/_____/ ________ Age: ________	Gender:	☐ Female ☐ Male
Address:	________________	City:	________________
State:	________________	ZIP Code:	________________
Phone:	________________	E-mail:	________________

SECTION B: PARENT/GUARDIAN DEMOGRAPHICS INFORMATION *(please print clearly)*

First Name:	________________	Last Name:	________________
Date of Birth:	_____/_____/ ________ Age: ________	Gender:	☐ Female ☐ Male
Address:	________________	City:	________________
State:	________________	ZIP Code:	________________
Phone:	________________	E-mail:	________________
Relationship:	________________	Driver's License #:	________________

________(Please Initial) I certify that I have read and understand the Emergency Use Authorization Fact Sheet (EUA) for the Pfizer vaccine.

PLEASE SELECT TYPE OF CONSENT

☐ **CONSENT TO PERMIT CERTAIN INDIVIDUALS TO ACCOMPANY CHILD FOR IMMUNIZATION:**
I,____, hereby authorize the following individual to accompany my child to the Town of New Milford Department of Health COVID-19 Clinic for the provision of immunization services.

First Name:______________________________________Last Name: ____

Phone Number:__________________________________Relationship: ____

OR

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT THE TOWN OF NEW MILFORD DEPARTMENT OF HEALTH COVID-19 CLINIC:**
I,____, request and authorize the Town of New Milford Department of Health COVID-19 Clinic and its personnel to administer the requested immunization(s) to my MINOR CHILD.

Please Note: Teen drivers will be asked to stay in our waiting area 15 minutes POST injection for their safety.

This Authorization to Consent for Treatment of Minor will expire on the following event:

☐ Minor's 18th birthday ☐ End of calendar year ☐ Other date:_____/______/________

Authorization and Consent

- I am the parent/legal guardian for the minor child listed in Section A above who is under the age of 18 years old.
- If the minor child exhibits adverse or allergic effects from the administrative of a vaccine, I authorize the Town of New Milford Department of Health COVID-19 Clinic to contact and/or administer emergency medical services.
- I understand that my insurance or existing payment method may be billed for the services rendered to the minor listed above.
- I understand this authorization is valid until the 18th birthday of the patient, expiration date noted above OR upon written revocation.
- I understand this Authorization to Consent for Treatment of Minor ("Authorization") does not release me (parent/guardian) from signing an informed consent if required by law. The Town of New Milford Department of Health COVID-19 Clinic Center may contact me to obtain verbal consent when additional informed consent is necessary.
- I understand this Authorization and the Vaccine Administration Record Form (Intake Form) must be completed prior to **EACH** unaccompanied visit at the Town of New Milford Department of Health COVID-19 Clinic.
- I have downloaded and read the Emergency Use Authorization (EUA). I request that the vaccine(s) be given to my minor child named above for whom I am authorized to make this request.
- I have read and understand the contents of this Authorization, which I voluntarily sign.
- A copy of this form shall remain on file in accordance with state and/or federal law.

Parent/Guardian Signature

Parent/Guardian Signature: ____ Date: ______________________

Print Name: ____