Updated 08/08/2021

ANTI-COVID19 VACCINATION

CONSENT FORM for minors

Name and Surname of the vaccine recipient :	
Date of birth:	Place of birth:
Telephone:	Address:

I, the undersigned_____born in…… on ……

residing at …… address ……

as **mother** [ ] legal representative [ ]

I, the undersigned_____born in…… on ……

residing at …… address ……

as **father** [ ] legal representative [ ]

- I have read, I have been informed in a language I speak and I have fully understood the Fact Sheet drafted by the Italian Medicines Agency (Agenzia Italiana del Farmaco, AIFA) regarding the vaccine: "……."
- I reported to the doctor the current and/or previous pathologies and the therapies being carried out by the vaccine recipient.
- I had the opportunity to ask questions regarding the vaccine and the vaccine recipient's state of health, obtaining exhaustive answers that I understood.
- I was correctly informed in words that were clear to me. I understand the benefits and risks of vaccination, the treatment options and alternatives, and the consequences of refusing to complete the vaccination with the second dose, if any.
- I am aware that in the event of any side-effects, it will be my responsibility to inform the attending physician immediately and to follow his instructions.
- I agree to allow the vaccine recipient to remain in the waiting room for at least 15 minutes after administration of the vaccine to ensure that no immediate adverse reactions occur.

I consent and authorize the administration of the vaccine "……" **to** ……..

PLACE AND DATE ……

Signatures of parents or Legal representative……

In case of absence of one of the parents, alternatively:

☐ a proxy for the absent parent's acceptance of the vaccination can be produced

☐ the parent present declares and signs that: the absent parent……. has been unable to attend, but consents to the vaccination

signature……

I refuse the administration of the vaccine "……"

Place and date ……..

Signature of the Person refusing the vaccine or their Legal representative ……

Health professionals in the vaccination team

1. Name and Surname (Doctor)……

I confirm that the vaccine recipient has given his/her consent to the Vaccination, after having been properly informed.

Signature ……

2. Name and Surname (Doctor or other Health Professional) …….

Role ……

I confirm that the vaccine recipient has given his/her consent to the vaccination, after having been adequately informed.

Signature ……

The presence of a second Healthcare Professional is not necessary if the Vaccination is administered at a doctor's office or in other settings where just One Doctor is operating, and in case of home vaccinations or logistic and organizational problems.