



CONSENT FOR TREATMENT OF A MINOR PATIENT

Minor Patient's Name

Date of Birth

Age

To facilitate medical care and treatment of my child, "Minor Patient," by Sutter Valley or Sutter Bay Medical Foundation the undersigned parent, legal guardian or other person with legal responsibility of the Minor Patient hereby agrees as follows:

1. I reviewed this consent form and have read and understand the "Fact Sheet for Recipients and Caregivers" about the potential risks and benefits of the COVID-19 vaccine indicated below.
2. I have the legal authority to consent to have the Minor Patient named above vaccinated with the COVID-19 vaccine indicated below and am authorized to make health care decisions on behalf of the Minor Patient.
3. I authorize healthcare providers at Sutter Valley or Sutter Bay Medical Foundation to engage in the following acts:

Direct Authorization for administration of COVID-19 Vaccine against Coronavirus Disease 2019 (COVID-19):

[Please Check Box/s]

Pfizer-BioNTech COVID Vaccine

Primary dose/series

Additional vaccine doses (as eligible)

Fact Sheets for Recipients and Caregivers

- [6 months and older](#)

Moderna COVID Vaccine

Primary dose/series

Additional vaccine doses (as eligible)

Fact Sheets for Recipients and Caregivers

- [6 months and older](#)

4. I authorize Sutter Valley or Sutter Bay Medical Foundation to provide the Minor Patient with medical care and treatment in my absence.
5. This authorization is given pursuant to the provisions of California Family Code Section 6910.
6. **Duration:** This authorization shall remain effective for 150 days or until _____, 20____. This authorization may be revoked by me at any time prior to that expiration date by providing Sutter Health with written notice.
7. **Exception:** I understand that the provider can decline the consent any time he or she feels it is necessary for the parent/guardian to be present for treatment.

Date

Signature

Print name

For office use only	MRN #