

## COVID Parental Consent for Students Aged 12 –17

I consent to allow my child to receive the Pfizer COVID-19 vaccine from  
Chippewa County Health Department.

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
DOB

Contact Information: \_\_\_\_\_

Allergies: \_\_\_\_\_

### Chippewa County Health Department



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