

Van Dorn Pediatrics and Adolescent medicine

2500 N Van Dorn St ste 102

Alexandria, VA 22032

I have read and understood the Emergency use authorization statement for COVID vaccines

Child's or Children's names: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent's name \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_