Consent for 2025-2026 Moderna Spikevax mRNA vaccination - Minors

I, the undersigned parent/guardian, have participated in a shared decision-making process with a clinical member of the team at Pediatric Associates of Western CT regarding the 2025-2026 Moderna Spikevax COVID-19 vaccination for my child.

The document named "Information for Recipients and Caregivers, Spikevax (COVID-19 Vaccine, mRNA) (2025-2026 Formula)" that discusses the vaccine ingredients, potential side effects, and procedure for administration was made available to me both prior and during the visit and I was afforded the opportunity to ask questions.

I understand that the vaccine is being administered according to the most current guidelines, including the 2025-2026 recommendations from the AAP (American Academy of Pediatrics), CDC (Center for Disease Control and Prevention), the ACIP (Advisory Committee on Immunization Practices), and CT state guidelines, using age-appropriate dosing recommendations.

I acknowledge that, as of now, the COVID-19 vaccine may be considered "off-label" for children who have no specific risk factors according to FDA (Food and Drug Administration) guidelines.

I understand that the COVID-19 vaccine may not fully prevent infection with COVID-19. I agree to proceed with vaccination and confirm that I am authorized to give consent.

I understand that Pediatric Associates of Western CT will bill my insurance, if applicable. If insurance does not cover the cost, I agree to pay any remaining balance.

_____ _____

Patient Name Patient DOB

_____

Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date

Spikevax Information for Recipients and Caregivers 2025-2026