KOHALA COAST URGENT CARE Minor COVID-19 VACCINATION/ RELEASE FORM

PLEASE FILL OUT LEGIBLY AND COMPLETELY, ALTERNATE PHONE NUMBER REQUIRED

PATIENT INFORMATION:

LAST NAME: ______________________ FIRST NAME: ____________________ MIDDLE INITIAL: _____

MAILING ADDRESS______________________________ CITY: _________________ ZIP CODE: ______________

PHYSICAL ADDRESS_____________________________ CITY: _________________ ZIP CODE: ______________

PHONE NUMBER _________________________ ALTERNATE PHONE NUMBER ___________________

DATE OF BIRTH: _______________ AGE: __________ GENDER: MALE / FEMALE

By signing this document, I am authorizing my child to: (select all that apply)

☐ Be tested for COVID 19 ☐Receive the COVID 19 Vaccination

Parent or Guardian Printed Name:____

Parent or Guardian Signature: ____

Date: ____________________