Covid-19 Vaccine Consent Form

Pediatric Care, Inc.
8752 Union Centre Blvd.
West Chester, OH 45069

Patient Name:_____ DOB:_____
Insurance: _____

SCREENING QUESTIONS FOR INDIVIDUAL RECEIVING THE VACCINATION – ANSWER THE DAY OF VACCINATION

Have you had any type of vaccine in the last two weeks?	☐ No ☐ **Yes**
Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ No ☐ **Yes**
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19? **If Yes, when?** _____	☐ No ☐ **Yes**
Have you been identified as either a probable or confirmed case of COVID-19 in the last two weeks?	☐ No ☐ **Yes**
Have you received antibody therapy for COVID-19 in the last 3 months?	☐ No ☐ **Yes**
Do you have any serious health conditions (often called co-morbidities)?	☐ No ☐ **Yes**
Do you have a weakened immune system or are you on immunosuppressive drugs?	☐ No ☐ **Yes**
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐ **Yes**
Are you pregnant or breastfeeding?	☐ No ☐ **Yes**
Do you feel sick today?	☐ No ☐ **Yes**
Today's dose is: ☐First Dose ☐Second Dose ☐Third Dose (Immunocompromised or <5 years) ☐ Bivalent Booster	

If you answered "Yes" to any of the above questions, please discuss with medical staff prior to vaccination

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination, you assume any risks associated with not waiting the recommended amount of time.

Printed Name: _____ Relationship to Patient: _____
Signature: _____ Date of Consent: _____

Office Use Only

Administration Date: _____ **Patient's Age at Time of Administration:** _____

Site: Right Arm Left Arm Right Thigh Left Thigh

Vaccine Given:

PFIZER PRIMARY SERIES: Maroon Cap (6 Months – 4 Years) Orange Cap (5-11 Years) Gray Cap (12 Years and Up)

MODERNA PRIMARY SERIES: Magenta (6 Months-5 Years) Purple (6-11 Years) Red (12 Years and Up)

BIVALENT BOOSTER: Pfizer (5-11 Years) Pfizer (12 Years and Up) Moderna (6 Years and Up)

Lot Number:_____

Date Documented on ImpactSIIS: _____ **Entered By (Initials):** _____