COVID-19 VACCINE smart start pediatrics

I request that the ☐ **Moderna** ☐ **Pfizer-BioNTech** COVID-19 Vaccine be given to me or to the person named hereafter for whom I am authorized to make this request (select one): ☐ MYSELF ☐ PERSON NAMED BELOW

Recipient Information

Name: _____ Age: _____

Address: _____

Street City State Zip

Telephone: _____ Covered by Insurance, Medicaid, or Medicare: Yes ☐ No ☐

Date of Birth:	Social Security #:	Gender (check one):	Primary Language:	Ethnicity:
_____	_____	☐Male ☐Female	_____	☐Hispanic ☐Non-Hispanic

Race (Check only one): ☐Black ☐White ☐Hispanic ☐Asian ☐American Indian ☐Other: _____

Emergency Contact: _____
Ph: _____ Relation: _____

Please answer the following medical screening questions:	**Yes**	**No**	**Unknown**
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine: ☐ Pfizer ☐ Moderna ☐ J&J Date received: _____	☐	☐	☐
3. Have you ever had an allergic reaction to a component of COVID-19 vaccine including either of the following: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)* • **Polyethylene glycol (PEG**), which is found in some medications, such as laxatives and preparations for colonoscopy procedures or • **Polysorbate**, which is found in some vaccines, film coated tablets, and intravenous steroids • A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had a serious reaction after receiving any other vaccine or injectable medication?	☐	☐	☐

5. Check **all** that apply to you

- ☐ A female between ages 18-49 years old
- ☐ A male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder or take a blood thinner
- ☐ Have received dermal fillers
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding

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ACKNOWLEDGEMENTS

- Prior to vaccination, I have been given a copy of and have read the Fact Sheet for Recipients and Caregivers for the vaccine that will be received today. I have had the chance to ask questions that were answered to my satisfaction.
- The FDA has authorized the emergency use of the COVID-19 Vaccine for various recipient groups.
- The recipient or their caregiver has the option to accept or refuse a COVID Vaccine at this clinic.
- The significant known and potential risks and benefits of COVID-19 Vaccines, and the extent to which such risks and benefits are unknown, have been disclosed to me.
- The Pfizer-BioNTech Vaccine is administered as a series of two doses given at least 3 weeks (21 days) apart. The Moderna vaccine is administered as a series of two doses given 4 weeks (28 days) apart. Recipients will be considered fully vaccinated 14 days after the second dose is received.
- Recipient must be 5 years of age or older to receive the Pfizer vaccine and 18 years of age or older to receive the Moderna vaccine.
- I have been advised to remain on site for 15 minutes after receiving the vaccine. Those with a history of previous anaphylactic reactions must stay on site for 30 minutes. I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.
- I have received or have been offered a copy of Smart Start Pediatrics' *Notice of Privacy Practices.*

VACCINATION CONSENT

1. I have reviewed this consent form and I understand that the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the COVID-19 Vaccine.

2. An administration fee may be billed to third party payors on my behalf. I authorize Smart Start Pediatrics to bill any and all third-party payors for this service. I authorize the release of any medical or other information necessary to process this claim and I authorize my insurance carrier to pay benefits for services rendered, directly to Smart Start Pediatrics or any of its affiliates.

SIGNATURE OF VACCINE RECIPIENT

_____ _____ _____

Printed Name of Recipient **Signature of Recipient** **DATE**

CONSENT FOR MINOR'S VACCINATION (REQUIRED FOR RECIPIENTS < 14 YEARS OF AGE):

By signing this form, you are stating that you have the legal authority to consent to have the child named on this form vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.

_____ _____

Signature of Authorized Representative **DATE**

_____ _____

Printed Name of Authorized Representative **Relationship to Person Receiving Vaccine**

Clear Form