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COVID-19 Immunization Screening and Consent Form

Vaccine Recipient Information

Patient Name:_____ **DOB:**_____

Parent/Guardian/Surrogate Name Printed Name: _____

1. Is you child feeling sick today YES___NO___ UNKNOWN___
2.In the last 90 days, has you child had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection YES___NO___ UNKNOWN___
3. Does your child carry an Epi-Pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex? YES_____ NO___ UNKNOWN___
4. Does your child take any medications that affect your immune systems, such as cortisone, prednisone or other steroids, anticancer drugs, or has your child had any radiation treatments? YES___ NO___ UNKNOWN_____
5.Has your child received a previous dose of a COVID-19 vaccine? YES___ NO___ UNKNOWN_____
6. If so, did your child have any allergic symptoms after a COVID-19 vaccine? YES___ NO___ UNKNOWN_____

AUTHORIZATION AND CONSENT CONTINUED ON BACK

Authorization and Consent

CONSENT AND RELEASE: I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be given in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am guardian was also given a change to ask questions). I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination be given to me (or the person named above for whom I am guardian). I hereby release and forever discharge and hold harmless Providence Pediatric Practice, LLC, its doctors, nurses and employees for any and all liability, claims, demands, and/or cause of action, either in law or equity, which may arise from my receipt of the COVID-19 vaccine with respect to any bodily injury (including but not limited to potential allergic reactions and infections) or other injury, including and mental injury, illness, death or property damage that may result. I understand that Providence Pediatric Practice, LLC does not assume any responsibilty or obligation to provide financial assistance or other assistance, including, but not limited to medical, health, or disability insurance in the event of injury, death or property damage, unless otherwise expressly governed by and interpreted in accordance the laws of the shall be held to be invalid by and court of competent jurisdiction, the invalidity of such clause or provision shall not affect the remaining provisions of this Consent and Release.

CONSENT AND HIPPA PRIVACY INFORMATION: I have read the above Consent and Release and understand its provisions. I understand that participation in this COVID-19 vaccination program is completely voluntary and not required. I understand the risks and benefits of the vaccine and I request that the vaccine be given to me or the person named above for whom I am the legal guardian. I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccination provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I hereby freely and voluntarily without duress, execute this Consent and Release under the above written terms.

Signature_____Date_____

Relationship to patient (if other than recipient)

Printed Name:_____