

PROVIDENCE PEDIATRIC PRACTICE, LLC

100 Granite Drive, Suite 20C
Media, PA 19063-5134

(610) 565-1945 • Fax (610) 892-7848

Olivia T. DiMaggio, M.D.

Alison D. Gaudet, M.D.

Betsy G. Race, M.D.

Allison R. Horowitz, M.D.

COVID-19 Immunization Screening and Consent Form

Vaccine Recipient Information			
Patient Name: (Please Print)	Last	First	M.I
Date of Birth:		Parent/Guardian/Surrogate Printed Name:	

Screening Questionnaire				
		YES	NO	UNK
1	Is your child feeling sick today?			
2	In the last 10 days, has your 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 or exposure?			
3	Has your child been treated with antibody therapy for COVID-19 in the past 90 days (3 months) If yes, when did you receive the last dose? Date:			
4	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?			
5	Does your child take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or has your child had any radiation treatments?			
6	Has your child received a previous dose of a COVID-19 vaccine			
7	If so, did your child have any allergy symptoms after a COVID-19 vaccine?			

AUTHORIZATION AND CONSENT CONTINUED ON BACK

Emergency Use Authorization

The US Federal Drug Administration (FDA) has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine generally outweigh the known and potential risks.

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 chance 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 from 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 responsibility 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 Commonwealth of Pennsylvania. I agree that in the event that any clause or provision of the Release shall be held to be invalid by any 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 administrating the vaccine will be assigned and transferred to the vaccinating 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: Recipient/Surrogate/ Guardian		Date:	
Printed Name		Relationship to patient (If other than recipient)	