

**Recipient Name**: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ **Recipient Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No email

**Recipient Race:** [ ]  American Indian/Alaska Native [ ]  Asian [ ]  Black/African American

[ ]  Native Hawaiian or Other Pacific Islander [ ]  White [ ]  Other [ ]  Unknown

**Recipient Ethnicity:** [ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Unknown

**Recipient Gender**: [ ]  Male [ ]  Female [ ]  Other [ ]  I do not want to specify

I certify that I am able to consent for this COVID19 vaccine against this communicable disease or I am the parent or legal guardian of the above named patient if they are a minor. I consent to receive the vaccine and for my demographic and health condition information to be shared with the COVID-19 Management System (CVMS) as required. I have received a copy of the Emergency Use Authorization Fact Sheet on the Pfizer COVID-19 vaccine (QR code 5-11 yr old is top right and 6mo-4 yo is middle). I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction after leaving the office, I will call 911 or go to the nearest hospital. Bottom right QR for V-Safe tool to connect to CDC about your vaccine.

I authorize payment from private Insurance or Medicare/Medicaid to be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature below will serve as legal “signature on file” for purposes of filing insurance/Medicaid claims and payment of benefits to Pediatric Partners. **THE COVID VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL**. No out-of-pocket cost to you by Federal Law!

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Parent/guardian must sign if <16 yo**)

**Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other\_\_\_\_\_\_\_\_ ☐ 1st dose ☐ 2nd ☐ 3rd ☐ Booster**

**Administration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pfizer COVID19 vaccine (COMIRNATY)**

**Lot #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Exp:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ **Vaccine administered by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Patient ID#\_\_\_\_\_\_\_\_\_ Athena NCIR