The Kidz Docs/Trusted Doctors COVID-19 Vaccine Consent Form

Patient's Name (the person getting the vaccine)____

Date of Birth____________________________________

Please answer the following questions:

1) Has the patient ever received a dose of the COVID-19 vaccine (Pfizer, Moderna, other)?

Yes No

a) If so, which one?________________________________

b) If so, what was the date of the first dose?__________________________________

2) Has the patient ever had a severe allergic reaction (anaphylaxis) to anything?

Yes No

3) Has the patient ever had a severe allergic reaction after receiving a COVID-19 vaccine, another vaccine, or injectable medication?

Yes No

4) Has the patient had a severe allergic reaction to a component of the COVID-19 vaccine, including polysorbate or polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?

Yes No

5) Has the patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?

Yes No

6) Does the patient have a weakened immune system caused by something such as HIV infection or cancer, or take any immunosuppressive drugs or therapies?

Yes No

7) Does the patient have a bleeding disorder or is taking a blood thinner for any other reason?

Yes No

8) Is the patient in quarantine or isolation for COVID-19?

Yes No

Acknowledgment:

I (the patient) agree to WAIT near the clinic location for 15 minutes after receiving the vaccine, or 30 minutes if there is a previous history of a severe allergic reaction to a vaccine or injectable medication.

I (the patient) understand that the vaccine is being given under an emergency use authorization from the FDA and has only been approved for emergency use for patients 5-11 years of age. The Pfizer COVID vaccine has received full FDA approval for patients over 16 years of age. It is possible, though unlikely, that final approval of the vaccine will not ultimately be given for patients under 15 years of age.

I (the patient) understand this vaccine requires two doses and that due to vaccine supply shortages The Kidz Docs/Trusted Doctors will not be able to guarantee that I (the patient) will be able to receive a second dose. The Kidz Docs/Trusted Doctors will work to acquire adequate doses but can not guarantee that we will receive their requested amounts from the manufacturer because of supply chain restrictions outside of their control.

I (the patient) understand there are no guarantees this vaccine will provide immunity to me, and that I (the patient) should continue protective measures including masking, social distancing, and handwashing. The Kidz Docs/Trusted Doctors makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I (the patient) certify that I (the patient) do not have any contraindications to receiving this vaccine as outlined in the vaccine information sheet, including but not limited to a history of significant allergic reactions to a previous COVID-19 vaccine or any of its components.

I (the patient) understand that the common risks associated with the COVID-19 vaccine include, but are not limited to, pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell, or swollen lymph nodes (lymphadenopathy). I (the patient) understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing), swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness, and/or weakness. I (the patient) understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I (the patient) also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I (the patient) understand that the long-term side effects or complications of this vaccine are not known at this time.

I (the patient) will contact my physician or go to an urgent care or emergency room for assistance if I (the patient) have any concerns or adverse reactions.

I (the patient) understand that there are no data on the safety of COVID-19 vaccine in pregnant or lactating women and I (the patient) have consulted with my personal physician for information on the risk and benefits of the vaccine. I (the patient) further understand that The Kidz Docs/Trusted Doctors will not be liable to the patient of the patient's fetus/child for any harm related to acceptance of the vaccine.

I (the patient) understand Trusted Doctors and its Divisions (including The Kidz Docs) is immune under both Federal and State law from liability related to this vaccine. This means that I (the patient) will not be compensated by Trusted Doctors and its Divisions for any adverse effects experienced.

I (the patient) understand that the vaccine is given by The Kidz Docs, a division of Trusted Doctors. The owner and/or operator of this site, their affiliates, officers, directors, employees, and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of The Kidz Docs/Trusted Doctors giving the COVID-19 vaccine. I (the patient), for myself and my heirs and family members, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless Trusted Doctors, its subsidiaries, division, affiliates, successors, assigns, officers, trustees, employees, volunteers, and agents from any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions, and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrence, omissions, and like related to, or arising out of, directly or indirectly, my receipt of the COVID-19 vaccine.

I (the patient) understand that The Kidz Docs/Trusted Doctors will be required to report any reaction or side effects experienced to state and Federal authorities and consent to this disclosure. I (the patient) further understand and agree that The Kidz Docs/Trusted Doctors is required to submit COVID-19 vaccine administration data to the Virginia Immunization Information System (VIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I (the patient) was provided an opportunity to ask questions, which were answered to my satisfaction. I (the patient) understand the benefits and risks of the vaccine and request the vaccine be given to me.

WHAT TO DO IF YOU HAVE A REACTION TO THE COVID-19 VACCINATION

--Most people have side effects from the vaccination, but these usually only last 24 – 48 hours after receipt of the vaccination. A few people may have no side effects at all. Most people will experience pain, redness and/or soreness at the injection site. Many people will have a headache, fever, chills, muscle pain and/or fatigue from the vaccine, particularly after the second dose. A few people will have nausea or swollen lymph nodes (lymphadenopathy).

--In rare circumstances, the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing), swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness.

What should you do if you have a reaction?

If you experience any of the following:
--Red, sore arm at and around the injection site:
--Apply an ice pack to the affected area for comfort.

--If condition does not improve or worsens in 24 to 48 hours, call your physician.

--Fever, achiness, fatigue and/or headache:
--For adults 16 and over: Take the non-prescription product that you would usually use for discomfort or fever relief as needed.

--If condition does not improve or worsens in 24 – 48 hours, call your physician.

--Unusual or severe reaction (for example, hives, difficulty breathing, wheezing, allergic reaction):
--Immediately call your physician, call 911 or go to the emergency room or nearest urgent care center.
--In addition, you may report vaccine side effects to the FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html

Information about the COVID-19 Vaccine

- **The COVID-19 vaccines are not live virus vaccines so the vaccines cannot infect anyone with COVID-19.**
- **All needles and syringes are sterile, are one-time use and are safely discarded.**

- **According to data, the COVID-19 vaccine has approximately a 94% success rate in completely protecting those who receive it. The remainder have partial protection and will have greatly lessened symptoms if they do contract COVID-19.**
- **The vaccine will begin to provide protection about one to two weeks after the second shot of the series is given.**
- **At this time, we do not know how long the COVID-19 vaccine is effective for, so you may need future vaccines to remain protected.**
- **While the COVID-19 vaccination does provide protection against infection or greatly lessened symptoms if you contract COVID-19, you should continue to practice hand hygiene and use appropriate personal protective equipment (PPE).**

I (the patient or parent/guardian if patient is under 18 years of age) have read, understand and agree to all of the above and I (the patient or parent/guardian if patient is under 18 years of age), hereby give my consent to the staff of Trusted Doctors to give the patient a COVID-19 vaccine.

Signature of Patient (or parent/guardian if patient < 18 yrs): ____

Name of Signer: _________________________________

If patient under 18 years of age, relationship to the patient:_______________________________

Date:___________________

Financial Acknowledgement

THERE IS NO COST TO YOU. I (the patient) hereby authorize The Kidz Docs/Trusted Doctors to apply for benefits on my behalf for all services rendered with my insurance. I (the patient) certify the information provided regarding my insurance coverage is correct. I (the patient) further authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I (the patient) request payment of authorized benefits be made payable to The Kidz Docs/Trusted Doctors on my behalf.

If I (the patient) do not have insurance, I (the patient) have truthfully indicated above and will not be responsible for the cost. I (the patient) acknowledge that if I (the patient) do not have insurance, my information will be submitted to the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) so that The Kidz Docs Trusted Doctors will be funded for the cost of my immunization administration.

I (the patient or parent/guardian if patient is under 18 years of age) have read the above and have provided The Kidz Docs/Trusted Doctors with true and correct information and will notify The Kidz Docs/Trusted Doctors of any changes in health insurance coverage.

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Signature

____

Name of Signer

____

Date

____

Relationship to Patient (if patient is under 18 years of age)

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Name of patient (if patient is under 18 years of age)