VIRGINIA PEDIATRIC AND ADOLESCENT CENTER

Fostering the growth, health, and happiness of your children

COVID-19 VACCINE CONSENT

PATIENT'S LEGAL NAME (PRINT)	
DOB	
PHONE NUMBER	
E-MAIL	
ADDRESS	
GENDER	
RACE/ETHNICITY	
If this is Dose #2, brand of Dose #1 and Date Given	Brand: _____ Date: _____

THIS FORM SHOULD BE COMPLETED AND SIGNED BY THE PATIENT IF AGE 18+, BY A PARENT/GUARDIAN IF < 18.

Please initial that you have read and understand the following:

I declare that the vaccine recipient ("the patient") is 12 years of age or older. I further declare the patient:

_____ 1. Has not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.

_____ 2. Has not had any other vaccinations in the previous 14 days (e.g. MMR, Varicella, or a TB skin test).

_____ 3. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.

_____ 4. Has not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.

_____ 5. Has **not** tested positive for COVID-19 within the past 10 days or is **not** currently in quarantine for COVID-19 exposure.

_____ 6. Is not allergic to the following ingredients in the COVID-19 vaccine: mRNA, lipid nanoparticles, lipids((4-hydroxybutyl)azanediyl)bis(hexane-6, 1-diyl)bis(2-hexyldecanoate), 2[(polyethylene glycol)-2000]-N, N-ditetradecylacetamide, 1, 2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate or sucrose.

I understand that if the patient has any of the above conditions, the patient could be at increased risk of having a negative reaction or problem from the vaccine.

I further declare that if the patient has any of the following conditions, I have had the opportunity to speak with the patient's primary care provider and am making an informed decision to have the patient receive the vaccine (please still initial all spots below even if not applicable to this patient—can mark N/A and initial if desired, or just initial):

_____ 1. Have a history of anaphylaxis due to any cause.

_____ 2. Pregnant, attempting to become pregnant or breastfeeding;

_____ 3. Have a bleeding disorder or are on a blood thinner;

_____ 4. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

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Patient's Name:	DOB:

I agree to WAIT near the clinic location for 15 minutes after receiving the vaccine. If the patient has previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT near the clinic location for 30 minutes after receiving the vaccine. I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that the patient will receive the first and second part of the vaccine series. I 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 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 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 also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Virginia Pediatric & Adolescent Center (VPAC). The owner(s) and/or operator(s) 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 VPAC giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless VPAC, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against 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, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. VPAC makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness or a particular purpose regarding the vaccine or its effectiveness. I acknowledge receipt of VPAC's Notice of Privacy Practices.

I have read and understood "What To Do If You Have A Reaction To The COVID-19 Vaccination" and the "Fact Sheet" by the FDA regarding the COVID-19 Vaccination. I further understand and agree that VPAC 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 understand and agree to all of the above and I hereby give my consent to the staff of VPAC to give me or my child (if under age 18 years) a COVID-19 vaccine.

Parent/Legal Guardian/Patient(18+) - **SIGNATURE**	
Parent/Legal Guardian Name - **PRINT**	
Date	

Office Use Only

BRAND:	Dose 1	or	Dose 2	(Circle One)
LOT #				
EXPIRATION:				
IM LOCATION GIVEN	Right Deltoid	or	Left Deltoid	(Circle One)
ADMINISTERED BY: (SIGNATURE AND TITLE)				