AKSHAR PEDIATRICS

7474 Limestone Dr, Gainesville VA 20155 | (P) 703-721-7218 | (F) 703-721-7219

COVID-19 VACCINE CONSENT FORM

Name:_____

Patient's Name (the person getting the vaccine): _____

Acknowledgement

1. Has the patient ever received a dose of COVID-19 vaccine (Pfizer, Moderna, other)?
    a. If so, which one? _____
    b. If so, what was the date of first dose? _____
2. Has the patient ever had a severe allergic reaction (anaphylaxis) to anything?
3. Has the patient ever had a severe allergic reaction after receiving a COVID-19 vaccine, another vaccine, or injectable medication?
4. Has patient had a severe allergic reaction to a component of the COVID-19 vaccine, including polysorbate or polyethelene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?
5. Has the patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?
6. Has the patient received any vaccine in the last 14 days (excluding COVID vaccine)?
7. Does patient have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
8. Does patient have a bleeding disorder or are you taking a blood thinner?
9. Is the patient in quarantine or isolation for COVID-19?

Acknowledgement

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 the vaccine is being given under an emergency use authorization from the FDA and has only been approved for emergency use. It is possible, though unlikely, that final approval of the vaccine will not ultimately be given.

I (the patient) understand this vaccine requires two doses and that due to vaccine supply shortages that Trusted Doctors will not be able to guarantee that I (the patient) will be able to receive a second dose. Trusted Doctors will work to acquire adequate doses but cannot guarantee that Trusted Doctors will receive their requested amounts from 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. 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 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.

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, join 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 studies 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 in pregnant or lactating women and I (the patient) have consulted with my personal physician for information on the risks and benefits of the vaccine. I (the patient) further understand that Trusted Doctors nor its Divisions will not be liable to the patient or the patient's fetus/child for any harm related to acceptance of the vaccine.

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

I (the patient) understand that the vaccination is being given by 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 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, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from an 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.

I (the patient) understand that Trusted Doctors will be required to provide certain demographic data, as well as any reaction or side effects experienced to state and Federal authorities and consent to this disclosure. I (the patient) further understand and agree that 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 18 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:_____

PATIENT INFORMATION (The Person Getting the Vaccine):

Patient's First Name:_____

Patient's Last Name:_____

Patient's Date of Birth: _____

Patient's Full Address (Street, City, State, Zip code):

_____

Patient's (or Parent/Guardian if patient<18yrs) Email :_____

Patient's (or Parent/Guardian if patient<18yrs) Phone Number:_____

***REQUIRED FOR REPORTING TO THE HEALTH DEPARTMENT (PROVIDE THE PATIENTS INFORMATION)**

Patient's Gender: _____

Patient's Race: _____

Patient's Ethnicity: _____

Do you have insurance? Yes or No:

If yes, INSURANCE INFORMATION (REQUIRED):

POLICY HOLDER:_____

POLICY HOLDER DATE OF BIRTH:_____

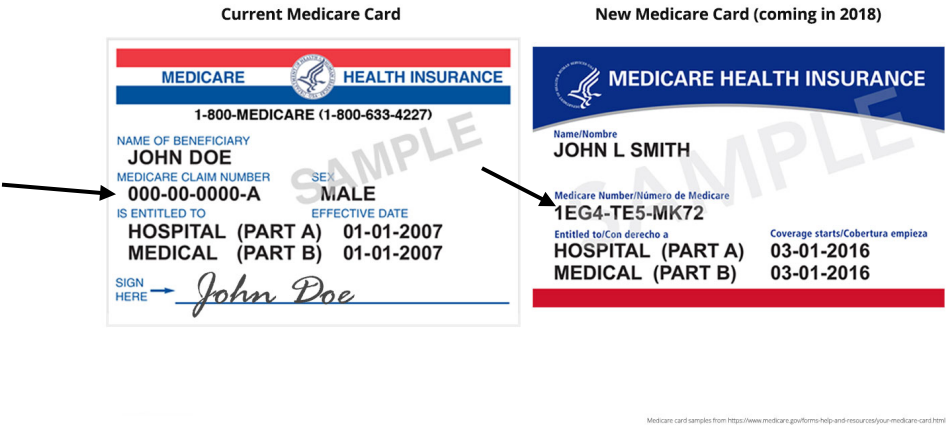
INSURANCE COMPANY:_____

INSURANCE CLAIM'S ADDRESS:_____

GROUP NUMBER:_____

SUBSCRIBER ID:_____

SAMPLE MEDICARE CARD



Medicare card samples from https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html

PICTURE OF FRONT AND BACK OF INSURANCE

FRONT **BACK**

THERE IS NO COST TO YOU. I (the patient) hereby authorize 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 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 Trusted Doctors will be funded for the cost of my immunization administration.

If I (the patient) have Medicare, Medicaid or other government insurance, I (the patient) authorize the release of my medical or other information necessary to process this claim. I (the patient) also request payment of government benefits either to myself or to the party who accepts assignment.

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

_____

Signature

_____

Name of Signer

_____

Date

_____

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

_____

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