Penguin Pediatrics PLLC

COVID-19 Vaccine Consent Form

Name:_____

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

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

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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 Penguin Pediatrics will not be able to guarantee that I (the patient) will be able to receive a second dose. Penguin Pediatrics will work to acquire adequate doses but cannot guarantee that Penguin Pediatrics 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. Penguin Pediatrics 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 Penguin Pediatrics 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 Penguin Pediatrics and its Divisions for any adverse effects experienced.

I (the patient) understand that the vaccination is being given by Penguin Pediatrics. 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

Penguin Pediatrics 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 Penguin Pediatrics, 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 Penguin Pediatrics 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 Penguin Pediatrics 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:

- 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 Penguin Pediatrics 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:_____