Beacon Pediatrics COVID-19 Vaccination Consent Form

Last Name | First Name | Date of Birth

Address | City | State | Zip

Place of Employment | Primary Phone Number

Please Circle:

Race: American Indian/Alaska Native | Asian | Black/African American | White | Other Race | Unknown | Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic | Not Hispanic/Latino | Unknown

Insurance Information

Primary Insurance Name: _____ Group #: _____ Insurance ID/Cert#: _____

Policy Holder Name: _____ DOB: _____ Patient Relationship: _____

Please read the statements below carefully and write yes or no in the right-hand column. You must answer all statements if you wish to receive the COVID-19 vaccination.	**YES or NO**
Are you severely ill today, or have you had a fever in the last 24 hours?	
Have you had a severe allergic reaction to any food, drugs, insect bites/sting in the past?	
Have you had a serious allergic reaction after receiving a vaccination in the past?	
Have you had an immediate allergic reaction of any severity to Polyethylene glycol or Polysorbate?	
Have you received monoclonal antibodies, IVIG, or plasma treatments within the past 90 days?	
Have you received another vaccine within the past 14 days?	
Have you received another COVID-19 Vaccination prior to today?	
Are you currently in quarantine due to having COVID-19 or having an exposure to someone with COVID-19?	

Beacon Pediatrics and its employees expressly disclaim any responsibility with respect to the vaccination procedure. My signature below indicates that I accept the Emergency use Authorization (EUA) and understand the potential side effects identified during the trial of this vaccine. My signature represents agreement to release Beacon Pediatrics from any and all claims arising out of, in connection with, or in any way related to my receipt of this COVID-19 vaccine. My signature further verifies my answers to the statements above. I understand that I may not be able to receive the vaccination from Beacon Pediatrics if any of the above questions are answered YES. My signature also indicates that I give Beacon Pediatrics permission to bill my insurance company for this vaccination, however, you will not be held responsible for any unpaid balances related to the COVID-19 vaccination.

If you are a resident of the State of Delaware, today's COVID-19 vaccination will be added to the Federal Immunization Registry and the Delaware State Immunization Registry so your physician has access to that information.

Please circle the reason you are receiving the COVID-19 Vaccination:

Healthcare Worker | age>= 65 years old | Front Line Essential Worker (If so, please write in) _____

Other Essential Workers (If so, please write in) _____

High-risk Medical Condition (if so, please write in) _____

Moderate Risk Medical Condition (If so, please write in) _____ | Other (Please write in) _____

If less than 18 years old:

PARENT SIGNATURE: _____ **DATE**: _____

Participant Signature: _____ **Date**: _____