

**COVID vaccine < 5yo**

**Recipient Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Recipient Email Address:** \_\_\_\_\_  No email  
**Home Phone Number:** \_\_\_\_\_ **Mobile Phone Number:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_ **County:** \_\_\_\_\_ **State:** \_\_\_\_\_  
**Recipient Race:**  American Indian/Alaska Native  Asian  Black/African American  
 Native Hawaiian or Other Pacific Islander  White  Other  Unknown  


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**Recipient Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Unknown  


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**Recipient Gender:**  Male  Female  Other  I do not want to specify  


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**Preferred Language:**  English  Vietnamese  Arabic  French  
 Spanish  Hindi  Other  Decline to state  


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**Insurance:**  Medicaid  Private (eg BCBS)  Uninsured  
*(no out of pocket cost, info for statistics)*

I certify that I am able to consent for this COVID19 vaccine against this communicable disease since I am the parent or legal guardian of the above-named patient. I consent for them to receive the vaccine and for demographic info to be shared with the NC Immunization Registry as required. I have received a copy of the Emergency Use Authorization Fact Sheet (QR codes Moderna on top, Pfizer on bottom). I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction after leaving the office, I will call 911 or go to the nearest hospital. I authorize payment from private Insurance or Medicare/Medicaid to be made on my child's behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature below will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to Sandhills Pediatrics. **THE COVID VACCINES ARE FREE TO EVERYONE, REGARDLESS OF WHETHER YOU HAVE PRIVATE OR GOVERNMENT INSURANCE OR NO INSURANCE AT ALL.** If you are not an existing Sandhills Pediatrics patient, we need a copy of your insurance card so we can bill your insurance as required by the government (No out of pocket cost to you by Federal Law!)



Please sign up for the V-SAFE program on your smartphone to help CDC monitor side effects & safety - [vsafe.cdc.gov](https://vsafe.cdc.gov)

I would like for my child to receive the COVID vaccine from:

\_\_\_\_\_ Moderna (2 doses 4-8 weeks apart) or \_\_\_\_\_ Pfizer (3 doses- 1<sup>st</sup> to 2<sup>nd</sup> dose 3-8 weeks apart; 2<sup>nd</sup>-3<sup>rd</sup> 8 wks apart)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_ **(Parent/guardian must sign)**

**Site of Injection:**  Right Delt, IM  Left Delt, IM  RAT \_\_\_\_\_  LAT \_\_\_\_\_  1<sup>st</sup> dose  2<sup>nd</sup>  3<sup>rd</sup>  
**Administration Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time:** \_\_\_\_\_ Moderna(BlueCap) \_\_\_\_\_ Pfizer (MaroonCap)  
**Lot #:** \_\_\_\_\_ **Exp:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Vaccine administered by:** \_\_\_\_\_