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:** _____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

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

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

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

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

Disabilities: ☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological or Psychiatric)
☐ Neurological ☐ Physical (Mobility) ☐ Respiratory
☐ Sensory (Vision or Hearing) ☐ Other (Please Specify: _____)

I certify that I am able to consent for this COVID19 vaccine against this communicable disease or I am the parent or legal guardian of the above named patient if they are a minor. I consent to receive the vaccine and for my demographic and health condition information to be shared with the COVID-19 Management System (CVMS) as required. I have received a copy of the Emergency Use Authorization Fact Sheet on the Pfizer COVID-19 vaccine (QR codes 5-11yo on top, 12 yo+ 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 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 (No out of pocket cost to you by Federal Law!)

Signature _____Date _____

Print name_____ (**Parent/guardian must sign if <16yo**)

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other_____ ☐ 1st dose ☐ 2nd ☐ 3rd ☐ Booster
Administration Date: _____/_____/_____ **Time:** _____ Pfizer COVID19 vaccine (COMIRNATY)

Lot #: _____**Exp:** _____/_____/_____ **Vaccine administered by:**_____

Rev 10/30/2021