Pediatrics West Notice of Agreement for COVID19/SARS-CoV-2 Vaccination 2025-2026

The American Academy of Pediatrics (AAP) is strongly recommending COVID-19 vaccines:

All children ages 6-23 months without a contraindication should get vaccinated with a 2025-26 COVID vaccine formula regardless of whether they previously received any doses or have had a SARS-CoV-2(COVID-119) infection.

For children ages 2-18 years, the AAP recommends a single dose of age-appropriate 2025-26 COVID-19 vaccine regardless of vaccination status for those who:

- are at high risk of severe COVID-19
- are residents of long-term care facilities or other congregate settings
- have never been vaccinated or
- have household contacts at high risk for severe COVID-19

Children 2 through 18 years of age not included in the risk groups above, whose parent or guardian desires their protection from COVID-19 should be offered a single dose of age appropriate 2025-2026 COVID-19 vaccine.

This notice gives our medical opinion and recommendation, not an official insurance decision.

 The physicians and advanced practice providers at Pediatrics West recommend your child receive an annual COVID19/SARS-CoV-2 vaccination.

By signing below, I understand that I may be personally responsible for any amount my insurance company does not cover or has been applied towards my deductible or coinsurance. The immunization cost is expected to be about \$150.00.

I have read, or have had explained to me, information about the COVID19 vaccination. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the COVID19 vaccination be given to me or to the person below, for whom I am authorized to make this request.

Patient's Name	
Date of Birth	
Signature (parent/guardian)	
Today's Date	

 Is your child sick today or have a fever? 	Yes	No
2) Has your child ever had a significant allergic reaction to a vaccine or other injection?	Yes	No
3) Is your child immunocompromised?	Yes	No
4) Does your child have a bleeding disorder or taking a blood thinner?	Yes	No
5) Does your child have an allergy to	Yes	No
the components of the vaccine?	Parent Initals:	_

Patient Name:_____ Date of Birth:_____

**** BELOW IS FOR OFFICE USE ONLY ****

OFFICE USE ONLY- DO NOT WRITE BELOW				
☐ VFC- Medicaid		Spikevax (Red Label) -6 months		
☐ VFC- Self Pay		through 11 years- 0.25 mL Prefilled		
Private insurance		Spikevax (Blue Label)- 12 years and over- 0.5 mL Prefilled		
Site:	Temp:		EUA/VIS Given: Y N	
LD	Lot Number:			
RD	PCP: SN / HEH / SFE / CF / LA / ES			
□ נד	Date Administered:			
☐ RT	Administered By:			

