MODERNA COVID-19 VACCINE CONSENT FORM

Name (Please Print): _____ DOB: _____ Age: ____

Phone: _____

1. 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 the components of the vaccine?	YES	NO

Consent

I, the undersigned, give my consent for the COVID-19 Vaccine that I am requesting from Pediatrics West. I acknowledge that I have received the vaccine manufacturer Moderna COVID-19 Vaccine Fact Sheet for Recipients and Caregivers prior to receiving the vaccine and have had the opportunity to ask questions.

I understand the benefits and risk of the vaccine, and request it to be administered to me or the person for whom I am authorized to make consent.

Patient/ Parent or Guardian Signature: _____

Relationship to patient: _____ Date: _____

Pediatrics West, P.C.
health care for the growing years

3555 Lutheran Pkwy, Suite200 Wheat Ridge, CO 80033

Phone: 720-284-3700 Fax: 303-467-0525

13402 West Coal Mine Ave, Suite 200 Littleton, CO 80127

Phone: 303-973-9300 Fax: 303-973-9308

Medical Records/Referrals Fax: 303-431-1038

**** FOR OFFICE USE ONLY ****

<table>
<tr><th colspan="3">OFFICE USE ONLY- DO NOT WRITE BELOW</th></tr>
<tr><td colspan="2">☐ VFC- Medicaid
☐ VFC- Self Pay
☐ Private insurance</td><td>☐ Dark Blue Cap (Green Label) - 6 months – 11 years- 0.25 mL
☐ Dark Blue Cap (Blue Label) - 12 years and over- 0.5 mL</td></tr>
<tr><td>Site:
☐ LD
☐ RD
☐ LT
☐ RT</td><td colspan="2">Dose: ☐ 1st ☐ 2nd
EUA/VIS Given: Y ☐ N ☐
Lot Number: _____
PCP: SN / NB / SFE / CF / LA / ES
Date Administered: _____
Administered By: _____</td></tr>
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