ECU Health Physicians: Pediatric Immunization Patient Consent & Vaccine Administration Record

This dose is for patients ages 6 months to 4 years of age

Last Name: _____ **First Name**: _____ **MI** ____ **Date of Birth**: _____ **Sex**: M / F

Address: _____ **City**: _____ **State**: _____ **Zip**: _____ **Phone**: _____

County:_____ **Ethnicity (Circle One) Hispanic Non-Hispanic**

Email Address:_____

Race (Circle One): White American Indian or Alaska Native Asian Black or African American Other

Primary Insurance: _____ **ID#:** _____ **Group #:** _____

Cardholder Name:_____ **Cardholder Date of Birth:**_____

Please answer the following questions by placing an X in the answer box:	YES	NO	DON'T KNOW
1. Have you had a severe allergic reaction to a previous dose of mRNA COVID-19 vaccine or any components in the vaccine (including polyethylene glycol [PEG]?			
2. Have you had an immediate allergic reaction of any severity to polysorbate?			
3. Have you had a severe allergic reaction (e.g., anaphylaxis) after receiving another vaccine, medication, or ingesting food?			
4. Are you currently in quarantine for a known COVID-19 exposure or a positive COVID-19 test?			

Informed Consent, Waiver, and Notice of Privacy Practices: Please read the following statements and sign on the signature line below:

I hereby consent to engage in the vaccine service and authorize representatives of East Carolina University Brody School of Medicine Pharmacy Services to administer the vaccine(s) listed below. I am aware of the side effects of the vaccine(s) and request that it be given to me. ECU Health Physicians are not responsible for assuring that I have consulted with my physician with regard to my receipt of vaccine(s). I have received a copy of the Notice of Privacy Practices. In consideration of the vaccine(s) to be administered to me by ECU, I hereby assume all risks in connection with my participation and agree to hold East Carolina University, each of its officers, directors, agents and employees harmless from any and all injuries, claims, losses, damages, or liability arising out of or in any way connected with my participation in this service. I hereby waive for myself, my heirs, executors, and administrators all rights and claims for my participation in this program.

_____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) Date

This section to be completed by Immunization Staff

ICD-10:Z23

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA/LL/RL)	Admin Schedule	VIS Date	CPT Code
Covid-19 Vaccine Age 6mo-4yr.			Pfizer	59267-4315-2	3mcg		Monovalent		91318

Immunizer Signature/Title/ Date / /