larchmont pediatrics
pediatric and adolescent medicine

Covid Vaccine Registration and Consent to Administer Covid Vaccine

Name of Person Receiving Vaccine_____ Date _____

Date of Birth _____

Telephone Number _____

Home Address _____

Primary Care Physicians Name & Phone Number _____
(If other than Larchmont Pediatrics)

Please read the following and indicate "yes" or "no" for the person receiving the vaccine today:

Do you have any allergies?	YES OR NO
Do you have a fever today?	YES OR NO
Do you have bleeding disorder or use blood thinners?	YES OR NO
Are you immunocompromised or are on a medicine that affects your immune system?	YES OR NO
Are you pregnant or plan to become pregnant?	YES OR NO
Do you have a history of myocarditis or pericarditis due to Covid vaccine?	YES OR NO
Have you received another covid-19 vaccine?	YES OR NO
Have you had a severe allergic reaction to any ingredient of this vaccine?	YES OR NO
Have you had a severe allergic reaction after a previous dose of Covid vaccine?	YES OR NO

Printed Name of Person Giving Consent _____

Relationship to Patient_____

Signature_____ Date _____

COVID _____ left/right - arm/thigh _____
Lot # Site of Injection Administered By

Charges

I request that payment of authorized benefits be made on my behalf to Larchmont Pediatrics and assign the benefits payable to Larchmont Pediatrics. I authorize Larchmont Pediatrics to pursue payment for services and appeal the denial of payment for services on my behalf. If my claim is not covered by my insurance, I understand I will be responsible for payment. I understand that my health information may be disclosed as set forth in the Notice of Privacy Practices, or as necessary for payment or to report to county, state, and/or federal agency. I authorize Larchmont Pediatrics to contact me for any purpose by any means I have provided. I acknowledge that these communications or messages may contain protected health information. I consent to receive text messages, calls to my cell phone if provided, and/or communications using computer-aided technologies from Larchmont Pediatrics. Authorization: I certify that to the best of my knowledge and belief the information provided by me is complete and correct. I have reviewed both sides of this document and agree to the terms.

Charges Each dose of COVID Vaccine is $225.00 (If not covered by your insurance, you will be responsible for the charge.)

Dosing

Adults, through age 64 will only require 1 dose regardless of whether they have been previously vaccinated. Adults 65 and older may require a second dose 2 to 6 months after the first

Side Effects of the Covidvaccine

Side Effects of Spikevax®(COVID-19 Vaccine, mRNA:

• Injection Site Reactions: Pain, redness, swelling, or armpit/groin swelling and tenderness near the injection site (reported in up to 76% to 98% of recipients depending on age).

• Fatigue: Feeling tired or exhausted.

• Headache: Mild to moderate head pain.

• Muscle and Joint Pain: Aches in the muscles (myalgia) and joints (arthralgia).

• Chills and Fever: Shivering or elevated body temperature.

• Nausea or Vomiting: Upset stomach symptoms (more frequent in younger age groups). ***If you have any adverse or possible allergic reactions, (such as hives, pain, swelling, itching or burning) contact your primary care physician immediately or if severe, call 911**

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I have read and understand the above information and have had the chance to ask questions that were answered to my satisfaction

_____ _____

Signature Date