MODERNA COVID-19 VACCINE CONSENT FORM

Patient First and Last 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: ________________________

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="1">☐ VFC- Medicaid
☐ VFC- Self Pay
☐ Private insurance</td><td colspan="2">☐ (Green Label) - 6 months – 4 years- 0.25 mL Prefilled
☐ 1st Dose ☐ 2nd dose
☐ (Green Label) 5 years – 11 years- 0.25 mL Prefilled
☐ Spikevax (Blue Label) -12 years and over- 0.5 mL Prefilled</td></tr>
<tr><td rowspan="2">Site:
☐ LD
☐ RD
☐ LT
☐ RT</td><td>Temp:</td><td>EUA/VIS Given: Y ☐ N ☐</td></tr>
<tr><td colspan="2">Lot Number: ______________________
PCP: SN / NB / SFE / CF / LA / ES
Date Administered: __________________
Administered By: ___________________________</td></tr>
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