COVID-19 Vaccination Acknowledgement

_____(Initial) I agree to WAIT in the clinic for 15 minutes after receiving the vaccine, or 30 minutes if there is a previous history of a severe allergic reaction to a vaccine or injectable medication.

_____(Initial) I understand the vaccine is being given under an emergency use authorization from the FDA and has only been approved for emergency use. It is possible, though unlikely, that final approval of the vaccine will not ultimately be given.

_____(Initial) I understand this vaccine requires two doses and that due to vaccine supply shortages that My Kids Pediatrics and Adolescent Care will not be able to guarantee that I will be able to receive a second dose. My Kids Pediatrics and Adolescent Care will work to acquire adequate doses but cannot guarantee that My Kids Pediatrics and Adolescent Care will receive their requested amounts from manufacturer because of supply chain restrictions outside of their control.

_____(Initial) I understand there are no guarantees this vaccine will provide immunity, and that I should continue protective measures including masking, social distancing, and handwashing. My Kids Pediatrics and Adolescent Care makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

_____(Initial) I certify that I or my child receiving the vaccine does not have any contraindications to receiving this vaccine as outlined in the vaccine information sheet-- including but not limited to a history of significant allergic reactions.

_____(Initial) I understand that the common risks associated with the COVID-19 vaccine include, but are not limited to, pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, join pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing), swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness. I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studies in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

_____(Initial) I will contact a physician or go to an urgent care or emergency room for assistance if any concerns or adverse reactions.

_____(Initial) I understand that there are no data on the safety of COVID 19 in pregnant or lactating women and I have consulted with my personal physician for information on the risks and benefits of the vaccine. I further understand that My Kids Pediatrics and Adolescent Care will not be liable to the patient or the patient's fetus/child for any harm related to acceptance of the vaccine.

_____(Initial) I understand that My Kids Pediatrics and Adolescent Care is immune under both Federal and State law from liability related to this vaccine. This means I or my child receiving the vaccine will not be compensated by My Kids Pediatrics and Adolescent Care for any adverse effects experienced.

_____(Initial) I understand that the vaccination is being given by My Kids Pediatrics and Adolescent Care. The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any

responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of My Kids Pediatrics and Adolescent Care giving the COVID-19 vaccine. I, for myself and my heirs and family members, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless My Kids Pediatrics and Adolescent Care, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from an against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine.

_____(Initial) I understand that My Kids Pediatrics and Adolescent Care will be required to provide certain demographic data, as well as any reaction or side effects experienced to state and Federal authorities and consent to this disclosure. I further understand and agree that My Kids Pediatrics and Adolescent Care is required to submit COVID-19 vaccine administration data to the Virginia Immunization Information System (VIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

_____(Initial) I was provided an opportunity to ask questions, which were answered to my satisfaction. I (the patient) understand the benefits and risks of the vaccine and request the vaccine be given to me.

THERE IS NO COST TO YOU. I hereby authorize My Kids Pediatrics and Adolescent Care to apply for benefits on my behalf for all services rendered with my insurance. I certify the information provided regarding my insurance coverage is correct. I further authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to My Kids Pediatrics and Adolescent Care on my behalf.

If I do not have insurance, I have truthfully indicated above and will not be responsible for the cost. I acknowledge that if I do not have insurance, my information will be submitted to the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) so that My Kids Pediatrics and Adolescent Care will be funded for the cost of my immunization administration.

I (the patient or parent/guardian if patient is under 18 years of age) have read, understand, and agree to all of the above and I (the patient or parent/guardian if patient is under 18 years of age), hereby give my consent to the staff of My Kids Pediatrics and Adolescent Care to give the patient a COVID-19 vaccine.

Name of Patients: ______________________________________ ____

Name of Parent/Guardian: ____ Relationship to Patient: _________________

Signature of Parent/Guardian: _____________________________________ Date: ________________________________