Golden Gate Pediatrics **PARENT** COVID / Flu Shot Waiver

Parent/Caretaker's Name: _____ Date of Birth: _____

Child's Name: _____ Child's Date of Birth: _____

We offer seasonal influenza and COVID-19 vaccines for parents and caretakers of our patients. We offer this service as a convenience to you and are not establishing a patient/doctor relationship with you. We will bill your insurance for the vaccine and administration of the vaccine(s), but we cannot guarantee that we are in-network with your insurance plan or that your insurance plan will cover these services. If they do not cover these services, you will be financially responsible. The purpose of this notice is to help you make an informed choice about whether you want to and should receive vaccine(s).By signing below you agree: 1.) To take financial responsibility for the cost of the vaccine. 2.) That you acknowledge and understand the benefits and risks of the vaccination as described in the Vaccine Information Sheets.

Description of Vaccine(s): Administration of Influenza and/or COVID-19 Vaccine
COVID Vaccine - Cost: $160.00 (CPT code: 91322), COVID Vaccine Administration - Cost: $65.00 (CPT code 90480)
Influenza Vaccine - Cost: $55.00 (CPT Code: 90686), Influenza Vaccine Administration - Cost: $65.00 (CPT Code 90471)

Select one or both. I would like to receive:

❑ COVID vaccine ❑ Influenza vaccine

I request and consent that the vaccination be given to me.

Responsible Party signature: _____Today's Date: _____

Screening Checklist for Contraindications to COVID and/or Influenza Vaccines

The following questions will help us determine which vaccines you or your child may be given today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Y	N	Unknown
1. Is the patient sick today?			
2. Does the patient have allergies to medicine, food, a vaccine component, or latex?			
3. Has the patient had a serious reaction to a vaccine in the past, including feeling dizzy or fainting before, during, or after a shot?			
4. Has the patient, a sibling, or a parent had a seizure; has the patient had a brain or other nervous system problem, or Guillain-Barre?			
5. Has the patient ever been diagnosed with a heart condition (myocarditis or pericarditis) or has the patient had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?			
6. Has the patient ever felt dizzy or faint before, during, or after a shot?			
7. Is the patient anxious about getting a shot today?			

STAFF ONLY:
Form reviewed & vaccines administered by: _____ Date: _____