

Golden Gate Pediatrics COVID / Flu Shot Waiver

Name of Person Getting the Shot(s): _____ Date of Birth: _____

If name above is a Parent/Guardian, name of your child: _____ Child's Date of Birth: _____

We are pleased to offer both Influenza and COVID-19 vaccines for our patients as well as their parents and guardians. For parents and guardians, 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(s) 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 decision about whether you want to and should receive the 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: \$190.00 (CPT code: 91322)

Influenza Vaccine - Cost: \$75.00 (CPT Code: 90656)

Select one or both. I would like to receive:

COVID vaccine Influenza vaccine

Screening Checklist for Contraindications to COVID and/or Influenza Vaccines

The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you 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. Is the patient under the age of 65 years old?			
3. Does the patient have allergies to medicine, food, a vaccine component, or latex?			
4. Has the patient had a serious reaction to a vaccine in the past, including feeling dizzy or fainting before, during, or after a shot?			
5. 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?			
6. 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?			
7. Has the patient ever felt dizzy or faint before, during, or after a shot?			
8. Is the patient anxious about getting a shot today?			

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

Responsible Party signature: _____

Today's Date: _____

STAFF ONLY:

Form reviewed & vaccines administered by: _____

Date: _____