2024-2025 COVID-19 Seasonal Vaccine
Moderna 6m – 11y

Patient's Name _____ _____ **DOB** _____
Last First

Child's Primary Doctor _____ **Age**_____

Has your child ever had a COVID-19 vaccine before? ☐ **Yes** ☐ **No**
If not, and less than 5 years old, it is recommended to get 2 doses of the COVID-19 vaccine this year at least 1 month apart.

Has your child had a fever (temperature 100.4 degrees or more) in the last 3 days? ☐ **Yes** ☐ **No**
If yes, we are unable to administer the vaccine today. Please reschedule to another clinic date.

Has your child ever had a severe reaction to a vaccine or any injection in the past? ☐ **Yes** ☐ **No**
If yes, please discuss with a member of our clinical staff prior to receiving the vaccine.

Has your child ever had an allergic reaction to a component of the COVID-19 vaccine or a previous dose? ☐ **Yes** ☐ **No**
If yes, please discuss with a member of our clinical staff prior to receiving the vaccine.

Please be aware that the Moderna COVID-19 Vaccine 2024-2025 Formula is still under emergency use authorization (EUA) and is not fully FDA approved for individuals 6 months through 11 years of age. For more information on this vaccine and the EUA status, please visit https://www.hilliardpeds.com/covid-19-vaccine-scheduling/.

COVID-19 vaccines are no longer being provided free of cost by the US government and are now being billed to insurance for both the vaccine and the administration fee. Fully funded insurance companies are required to cover this vaccine but have up to 12 months to add it to their fee schedule. Self-funded plans that are grandfathered in are allowed to make their own determination for whether this vaccine will be covered, and if so, whether it will be paid for in full or apply a cost-share to the allowed fee.

_____ *initial* I understand that the COVID-19 Vaccine 2024-2025 Formulation is a new vaccine and may not be covered by my insurance, or if covered, may not be covered in full and that I will be responsible for any patient responsibility as a result. As a courtesy to you for your direct payment, the maximum Hilliard Pediatrics will charge you for the COVID-19 Vaccine 2024-2025 Formulation and administration fee is $200.00.

By signing below, you agree that you understand the benefits and risk for the vaccine, and you are asking that the vaccine be given to the person named on this form for whom you are authorized to make this request. After receiving your vaccine, we recommend your child wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination, you assume any risks associated with not waiting the recommended amount of time.

_____ _____ _____
Parent/Guardian Signature Relationship to Patient Today's Date

OFFICE USE ONLY		
VACCINATION HISTORY (UNDER 5 YEARS OF AGE ONLY) - If the patient is less than 5 years old, has the patient received a COVID-19 vaccine before? ☐ Yes ☐ No # of doses _____ - If yes, last dose manufacturer _____ and date: _____		
SITE OF INJECTION ☐ Left Deltoid ☐ Right Deltoid ☐ Left Thigh ☐ Right Thigh	LOT #	NURSE