University Place Pediatric Clinic

COVID-19 Vaccine Acknowledgement

Patient Information:

Today's Date_____ First Dose ☐ Second Dose ☐

First Name and Middle Initial	Last Name:	Phone Number:

Date of Birth:	SEX: (Circle one) Male Female Other	Address, apt/bldg. City/State/Zip

Insurance ID#, Name, Address, City, State, Zip	RACE (Circle One): Native American Indian or Alaska Asian Hawaiian or Pacific Islander Black or African American White	ETHINICITY (circle one) Hispanic or Latino Not Hispanic or Latino Unknown

WHY DO YOU NEED IDENTIFICATION? If patient is uninsured, one of the following are required to allow UPPC to be reimbursed.

SSN	Driver's License	State ID

Acknowledgement: I have been provided with the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that I am receiving. I have read or had read to me the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits and risks of vaccination. I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I have made the decision to receive the COVID-19 vaccine voluntarily and freely and I assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area or an area identified by my health care provider for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call my doctor, or call 911. I request that the vaccine be given to me or the stated person named above for whom I am authorized to make this request.

Disclosure of Records: I understand University Place Pediatric Clinic may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment or health care operations. I also understand University Place Pediatric Clinic will use and disclose my health information as described in University Place Pediatric Clinic's Notice of Privacy Practices.

Signature of patient to receive vaccine _____ Date _____

Signature of clinician administering vaccine _____ Date _____