Spring Pediatrics
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COVID-19 Vaccination Consent

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 6 Months of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Spring Pediatrics to administer the COVID-19 vaccine

- I certify that all of the preceding answers and information provided on pre-vaccination checklist are true and correct.

- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals of age 6 Months and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination.

- I acknowledge that I have been advised to remain at the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital

- I voluntarily elect to receive the COVID-19 vaccination at Spring Pediatrics after carefully considering the risks and benefits

- Spring Pediatrics advised me to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination

- I understand that the COVID-19 vaccinations given at Spring Pediatrics will be tracked and reported to Maryland Immunet and as otherwise required by the local, state and federal government.

Signature of Patient or Authorized Representative: _____**Date**: _____

Print Name of Representative and Relationship to Person Receiving Vaccine:

_____ _____

Name Relation