MT. AIRY PEDIATRICS, PC

Consent and Waiver

COVID-19 VACCINE ADMINISTRATION

This form is to acknowledge that healthcare workers from Mt. Airy Pediatrics, PC,is offering this service free of charge and is not charging for or requiring any insurance information from me as a part of this service. Insurance information is requested to bill for administration; it is not required and patients will not be billed if insurance declines to pay the administration fee. This vaccine provided to you is offered as a part of a charitable service.

For patients who are not enrolled in our practice, no record of the vaccine will be kept or maintained in any form except for required reporting as required by state and federal law and anyinformation to you about your particular vaccine will not be available to you in the future. It's your responsibility to keep up with any vaccine card and nothing will be kept on file for you to retrieve in the future.

The provider or healthcare organization who is sponsoring or working to give vaccines is not establishing a physician/patient relationship with you by undergoing this free service.

I have agreed that I have signed an informed consent and have answered the screening questions to the best of my ability. I,_____, acknowledge that I am receiving a COVID-19 vaccine through a specific manufacturer that has been outlined to me in advance of the vaccine.

I also understand that as a volunteer health care provider, the physician or nurse practitioner whois supervising the medical assistant is immune from civil liability for any act or omission resulting in death, damage, or injury as long as the volunteer acts in good faith and in the scope of his or her duties within the organization in providing the health care services.

The medical assistant administering the vaccine, under the overall supervision of a physician or nursepractitioner, is not administering care for or in expectation of compensation.

I agree that I will notify someone immediately if I begin to experience any symptoms of an allergic reaction. I agree to remain in the office for the specified time as outlined by the office staff to be observed for any adverse reaction and by signing this form, I agree to follow whatever instructions are given to me.

Furthermore, I realize that the civil liabilities of the employee of the organization are limited to money damages per state law. I hereby agree to RELEASE AND HOLD HARMLESS SURE,INC FROM ANY CLAIMS, DEMANDS, OR LIABILITIES ARISING FROM ANY PHYSICAL OR PSYCHOLOGICAL INJURY RESULTING FROM THIS VACCINE.

_____ _____

Patient's name Patient Signature

_____

Date