COVID-19 Vaccination Agreement

Recipient's Full Na	me:	Date of Birth:
1. I have requested	the COVID-19	9 vaccination for my child/myself.
2. I have been made proceed with vacci		e risks and benefits and through shared decision making, I wish to
Potential Benefits		
May reduce the ris	sk of COVID-1	19 infection.
May reduce sever	ity, complicat	tions, and risk of hospitalization if infected.
May contribute to	community p	protection by reducing transmission.
	headache, mı	s at injection site, redness at the site of injection, fever and/or chills, uscle aches, joint pains, nausea and vomiting, irritability or crying
	myocarditis/p	cions including anaphylaxis (1 per 5 million vaccines), low blood pressure pericarditis (rare & primarily reported in adolescent/young adult males),
_	_	insurance plan may not pay for this immunization due to non-coverage o ayment, or coinsurance.
above reasons, I wi	ll be billed by	e immunization and/or the administration fee is not paid due to any of the Mesquite Pediatrics and agree to pay upon receipt of the bill. The d I understand that the allowable amount may be slightly higher or lower
6m- 4yr 5 yr-11 yr 12+ yrs	\$147 \$ 86 \$161	VFC (AHCCCS & Self Pay Patients) \$20 per vaccination
	after it has alr	nge my mind and decide not to have my child or family member receive eady been made ready for administration, I will still be responsible to pay
By signing below, I to be bound by the	_	that I have read and understand the terms of this Agreement and agree
Signature:		Date:
Printed name of pa	rent/guardian	/responsible party