Bloomington Pediatrics 306 St. Joseph Dr., Bloomington, IL 61701 Phone: 309-662-0504

BLOOMINGTON PEDIATRICS CLIENT VACCINATION REGISTRATION FORM

Today's Date ____/____/_____

CLIENT: Last Name	**First Name**	**MI**	**Birth Date**	**Age**	**Male** **Female**

Address	**City**	**ZIP Code**	**Home Telephone Number**

Email	**Cell Number**

Name of Emergency Contact	**Relationship to Client**	**Telephone Number**

Race: (circle all that apply)	White	Black or African American	Native Hawaiian or Other Pacific Islander	Asian	American Indian or Alaska Native	Other Race:_____ Unknown

Ethnicity	Not Hispanic or Latino	Hispanic or Latino	Unknown

Insurance (circle all that apply)
Aetna Blue Cross/Blue Shield Cigna Coventry Health Alliance Health Link Humana Youthcare Medicaid Molina Meridian Meritain United Healthcare

Member Number on Card	**Group Number**	**Relationship to Client**

Member Name (if different from client)	**Birth Date**	**Member Employer**

Additional Information	**Member's Address (if different from client)**

ASSIGNMENT OF BENEFITS: I understand that the COVID-19 vaccine is free; however, a charge to my insurance may be made for the cost of administering the vaccine. I request that payment of authorized Medicaid, or other insurance company benefits be made to Bloomington Pediatrics for any services furnished to me by Bloomington Pediatrics. Regulations pertaining to Medicaid assignment of benefits apply. I understand that Bloomington Pediatrics is authorized to use the information gained during treatment to bill me or my insurance company. I also hereby acknowledge that I was offered and/or received a copy of the "Notice of Privacy Practices" from Bloomington Pediatrics. My signature indicates agreement to the above and that all information provided above is true/accurate:

_____ _____

Signature of Client or Legal Representative ***Date***

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Name_____ **Birth date**_____

5-11 AGE GROUP COVID-19 Questions

TO BE COMPLETED ON THE DAY OF IMMUNIZATION :

Yes	No	
		1. Are you ill today; do you have a fever?
		2. Have you ever received a dose of COVID-19 Vaccine? If so, what product and when? ☐ Pfizer ☐ Other: _____ Date of 1st Dose: _____
		3. Have you ever had a serious reaction to a vaccine or other injectable medication? Have you ever had a severe allergic reaction to anything that required treatment with an EpiPen (epinephrine) or a trip to the hospital? If yes, was this reaction to your 1st dose of COVID vaccine? ☐ NO ☐ YES
		4. Do you have a bleeding disorder or are you taking a blood thinner?
		5. Have you received passive antibody therapy as treatment for COVID-19?
		6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

COMMON SIDE EFFECTS: 1) Injection Site Reactions: pain, tenderness, swelling and redness, swelling of lymph nodes in the same arm as the injection; 2) General Side Effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever.
IF YOU EXPERIENCE ANY MORE SERIOUS REACTION THAN DESCRIBED, PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN.
Your signature below indicates consent to receive the COVID 19 vaccine.

_____ _____
Signature/Authorization of Client/Parent/ or Legal Guardian ***Date***

FOR CLINIC/OFFICE USE
Circle One: **Pfizer**

VACCINE ADMINISTERED: **COVID-19**

Circle One: DOSAGE: **0.2 mL (Pfizer) age 5-11**

VACCINE LOT NUMBER**:** _____ EXPIRATION DATE: _____

DATE OF ADMINISTRATION: _____ Vaccine Information Statement: EUA

SITE & ROUTE OF INJECTION: **Left** or **Right** **Deltoid IM** **or** **Quadricep IM**

SIGNATURE & TITLE OF VACCINE ADMINISTRATOR: _____