RECIPIENT CONSENT FOR COVID-19 VACCINE UNDER EMERGENCY USE AUTHORIZATION (EUA) FOR CHILDREN 6 MONTHS TO 12 YEARS

PATIENT NAME: _____ DOB: _____ AGE: _____

MEDICAL RECORD #: _____

The Pfizer-BioNTech COVID-19 vaccine to prevent coronavirus disease 2019 for children 6 months through 12 years of age is approved under an Emergency Use Authorization (EUA) by the U.S. Food and Drug Administration (FDA). The FDA may allow the use of unapproved medical products in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives. Children 6 mo to <5 yrs will have a 3-dose series; children >5 yrs to <12 yrs will have a 2-dose series.

I understand:

- This vaccine is authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA). It is unclear how long any potential benefits of the vaccine may last. Additional research is needed to answer this question.
- Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.
- My child may still become ill with COVID-19 and may be able to transmit the virus to other individuals.
- Common side effects for children 6 – 23 months include irritability, decreased appetite, soreness/redness/swelling at the injection site, fever, joint pain and lymph node swelling.
- Common side effects for children 2 – 12 years include soreness/redness/swelling at the injection site, fatigue, fever, headache, chills, muscle pain, joint pain and lymph node swelling.
- I understand and acknowledge a record of this vaccine administration will be reported to the state and/or federal regulatory bodies in compliance with reporting requirements. I agree and authorize the COVID-19 vaccine record to be shared with my child's primary care physician and included in his/her health record(s) for continuity of care purposes.

I am confirming:

- I have reviewed the vaccine EUA Fact Sheet or had its contents including the benefits, the usual and most frequent risks of receiving this vaccine, and alternatives explained based upon currently available information.
- I have had an opportunity to ask questions which have been answered to my satisfaction.
- I agree to keep my child at the vaccination location for at least 15 minutes after the vaccine is administered in the event of an adverse reaction.
- I understand that COVID-19 can have serious, life-threatening complications and there is no way to know how COVID-19 will affect my child. I further understand that a COVID-19 vaccine may help keep my child from becoming seriously ill, if he/she does become infected with COVID-19. (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)

Parent/Authorized Agent signature	**Printed name**	**relationship**	**Date/Time**
Physician	**Printed name**		**Date/Time**
Witness	**Printed name**		**Date/Time**

TIDELANDS HEALTH GENERAL
CONSENT FOR TREATMENT

Consent for Diagnosis and Treatment. I hereby request and consent to medical care given to me or my minor child at Georgetown Memorial Hospital, Waccamaw Community Hospital, Georgetown Physician Services, LLC d/b/a Tidelands Health Group, Tidelands Health ASC, LLC, or Tidelands Health Market Common, LLC (collectively, "Tidelands Health"), which may include routine diagnostic procedures and treatment the physician(s) or other practitioners involved in my/my child's care consider necessary. I understand I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency, or extraordinary circumstances. I further acknowledge that no guarantees have been made to me regarding the outcome of any medical, surgical, diagnostic, or therapeutic treatment or test. To protect myself/my child and others, I consent to have blood drawn and tested for infectious diseases, including but not limited to HIV/AIDS and hepatitis. I understand that some physicians and other practitioners provide their services as independent contractors to Tidelands Health, are not employees or agents of Tidelands Health, and that Tidelands Health is not liable for their acts or omissions.

Patient's Certification, Assignment of Insurance Benefits, and Guarantee of Payment. I certify that the information I have given in applying for payment under Medicare, Medicaid, or any other government or insurance benefits is correct. I authorize payment of hospital insurance, government, or other third-party benefits directly to Tidelands Health. I also authorize payment of surgical and/or medical benefits directly to all treating, consulting, and supervisory physicians and entities. As a courtesy, Tidelands Health will file my insurance when this assignment of benefits has been signed.

- I understand that any charges Tidelands Health quotes to me prior to the provision of medical treatment are only an estimate. These charges are based on the insurance benefits given to Tidelands Health by my insurance company and are subject to change due to my medical condition and any further testing or treatment that may be necessary.

- I understand that I am financially responsible for, agree to pay, and guarantee payment in full of all charges for services provided to me by Tidelands Health, independent physicians, or other independent health care professionals involved in providing treatment or consultation to me at Tidelands Health, even if such services are not covered by insurance. I understand that payment of estimated charges is due at the time of a non-emergent service unless previous arrangements have been made, and that my bill for any unpaid amounts will be sent to my address on file unless I request my bill to be sent to a different address. Any unpaid accounts of 90 days or more are subject to collection activity. If I have any such unpaid accounts, I understand that I will have to pay cash at the time of service for all future non-emergency services until my unpaid accounts are resolved. If I am uninsured or am having difficulty paying my bill, I understand Tidelands Health has a financial assistance program that may help me. I understand that I will be required to provide financial information to determine my eligibility for this program, and that I can get more information on this program by calling the patient financial services department at 843-520-8880 Option 2.

- I authorize Tidelands Health and any independent practitioner(s) that have provided services to me at Tidelands Health to act as attorney-in-fact (act with authority from me) for the limited purposes of: (1) collecting benefits from any responsible third party through whatever means necessary; and (2) endorsing benefit checks made payable to me and/or Tidelands Health, any of the individual entities named above, or such independent practitioner(s). If collection efforts are needed to obtain payment from me for the services and supplies provided, I agree to pay the costs of such collection efforts, including litigation or arbitration costs and reasonable attorneys' fees.

- I authorize payment of any refund of any overpaid insurance benefits to be made to the appropriate payor in accordance with my insurance policy conditions or any applicable benefit provisions. If any refund is due to me, I authorize the application of any refund to any amount that I am personally legally obligated to pay for services provided by Tidelands Health. I understand that any remaining credit due after payment of these outstanding amounts will be refunded to me.

Responsibility for Personal Valuables. If I bring money or other valuables during an inpatient hospital visit and do not give these items to an authorized hospital employee for safekeeping, or if I bring these items to an outpatient appointment or procedure, I release Tidelands Health from any responsibility or liability for the loss of or damage to any such items.

Automated Appointment Reminders. By supplying my home phone number/mobile phone number/email address, I acknowledge that Tidelands Health or a third-party automated outreach and messaging system may notify me of a pending appointment, missed appointment, wellness exam, lab results, or deliver any other health care message by call, email, or text message.

- To service my Tidelands Health account or collect any amounts I may owe, I consent for Tidelands Health or a third party acting on its behalf to call or text me at any phone number associated with my account, including through pre-recorded/automated voice and text messages. I understand that my cell phone carrier could charge me for these text messages and that I will be offered an easy way to opt out of these automated calls or text messages.

Use and Release of Medical Information. I acknowledge that Tidelands Health, licensed physicians, and other health care professionals involved in my care at Tidelands Health may use and release my medical information obtained during this visit for purposes of treatment, payment, and health care operations and otherwise as stated in the Tidelands Health Notice of Privacy Practices.

I understand that this consent will automatically expire in one year. I also understand that I may revoke or discontinue my consent at any time by notifying Tidelands Health in writing, except to the extent actions have already been taken based upon my consent. I understand and agree to the above releases, consents, authorizations, and assignments of benefits:

Signature:_____ Date:_____ Time:_____
(Patient or legal guardian/authorized representative if patient unable to sign)

Printed Name:_____ Relationship, if not Patient:_____

Signature:_____ Date:_____ Time:_____
(Insured/Guarantor, if different from Guardian/Representative)

Insured/Guarantor, if any: *(Please print name)*_____

Acknowledgment of Receipt of Tidelands Health Notice of Privacy Practices. If I am a first-time patient, I certify that I have received a copy of the Tidelands Health Notice of Privacy Practices. If I am a returning patient, I certify that I have been offered a copy of the Tidelands Health Notice of Privacy Practices.

Signature:_____ Date:_____ Time:_____