# 12 and older

## Contact information – person being vaccinated

Last Name: ___________________________________________ First Name: _____________________________

D.O.B: ____/____ /_______ Age: ______________ Contact #: (______ )_______-____________

Address: __________________________________________________________________________________________

☐ **Check here if person getting the vaccine does not have insurance**.

### INSURANCE INFORMATION

**Primary Insurance Carrier**: _______________________________________

Policy/ID/member #: __________________________________ Group #:_______________ _____________

**Policy holder, if different from the person getting vaccinated:**

Name: _____________________________________________________ D.O.B: _____/_____ /________

### AGREEMENT

By signing below, I understand, recognize, approve, and agree that:

- I have received and read the Fact Sheets regarding the use of FDA approved **PFIZER** COVID-19 vaccine: PFIZER
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the Pfizer COVID-19 vaccine for myself or for the person named above.

Signature: _______________________________________________________ Date: _____/_____ /_______
(of patient or parent/guardian)

117-06 225th Street 1st Floor
Cambria Heights, NY 11411
Tel (718) 712-8511
Fax (718) 527-5624
email: camkids2016@aol.com
www.camkids225.com