ANTIBODY TREATMENT SIGN IN

Last name/ First Name: _____ DOB (mm/dd/yyyy:)_____

Gender: _____ SSN: _____ Primary Doctor: _____

Phone # and email: _____

Emergency Contact and #_____

I give FirstKids access to my medical history. Yes ☐ No ☐

Covid Symptoms:

Allergies:

Medical conditions:

Current medications:

The following medical conditions or other factors may place adults and pediatric patients (age 12-17 years and weighing at least 40 kg) at higher risk for progression to severe COVID-19:

- Older age (for example, age ≥65 years of age)
- Obesity or being overweight (for example, BMI >25 kg/m2 or if age 12-17, have BMI ≥85th percentile for their age and gender-based on CDC growth charts, https://www.cdc.gov/growthcharts/clinical_charts.htm)
- Chronic kidney disease
- Diabetes
- Immunosuppressive disease or immunosuppressive treatment
- Cardiovascular disease (including congenital heart disease) or hypertension
- Chronic lung diseases (for example, chronic obstructive pulmonary disease, asthma [moderate-to-severe], interstitial lung disease, cystic fibrosis, and pulmonary hypertension)
- Sickle cell disease
- Neurodevelopmental disorders (for example, cerebral palsy) or other conditions that confer medical complexity (for example, genetic or metabolic syndromes and severe congenital anomalies)
- Having a medical-related technological dependence (for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19)

☐ *I have confirmed exposure to COVID-19.*

☐ *I am symptomatic but not yet progressed to require hospitalization or oxygen therapy.*

☐ *I am high risk. Please reference high risk column.*

_____ _____ _____

Signature of Recipient or Parent/ Guardian | Date | Time

ANTIBODY TREATMENT SPECIAL CONSENT

Name: _____

DOB: _____

I, the undersigned, acknowldge and agree to the following:

I have been provided the "Fact Sheet for Patients, Parents, and Caregivers" and have been given the opportunity to review the Fact Sheet.

I have been informed that the REGEN-COV (casirivimab and imdevimab) Antibody treatment is not fully approved by the Food and Drug Administration but it is authorized for use by the FDA under an Emergency use Authorization.

I understand that in case of emergency, FirstKids staff will only provide Basic Life Support and call 911.

I am aware that is strongly recommended that I consult with my physician about the treatment, its risks and side effects and/ or its appropriateness for me before receiving the treatment.

I understand that the I must meet the qualifications previously provided to me to receive the full benefits of the antibody treatment.

Based on the information provided, I consent to the administration of the REGEN-COV (casirivimab and imdevimab) Antibody Treatment.

_____ _____ _____

Signature of Recipient or Parent/ Guardian | Date | Time

_____ _____

Witness Signature | Witness Name