COVID-19 SPIKEVAX Consent Form and Record

Must be 12 years of age or older

Must remain in pharmacy for 15 minutes after injection

PERSONAL INFORMATION	
	PATIENT NAME:
	DATE OF BIRTH: Phone#
	ADDRESS:
	Email:
	Primary Care Physician:
	ALLERGIES/MEDICAL ALERT:

SCREENING QUESTIONS:		
1. Are you feeling sick today?	☐ YES	☐ NO
2. Are you at least 12 years of age?	☐ YES	☐ NO
3. Have you ever had a reaction after receiving a vaccination, including fainting, or feeling dizzy?	☐ YES	☐ NO
4. Have you received a dose of any COVID-19 vaccine WITHIN THE LAST 2 MONTHS? If YES, please wait until it has been at least 2 months since your last dose to get this vaccination.	☐ YES	☐ NO
5. Have you had COVID in the last 3 months? If YES, you may delay your next vaccine by up to 3 months from the start of sx or positive test.	☐ YES	☐ NO
6. Have you ever had an allergic reaction to: (includes a severe allergic reaction (eg. Anaphylaxis) that required treatment with EpiPen or caused you to go to the hospital OR occurred within 4 hrs and caused hives, swelling or respiratory distress/wheezing).		
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures OR Polysorbate	☐ YES	☐ NO
• A previous dose of COVID-19 vaccine or another vaccine?	☐ YES	☐ NO
7. Have you ever had a severe allergic reaction (eg. Anaphylaxis) to something else, such as food, pet, environmental, or oral medication allergies.	☐ YES	☐ NO
8. Have you received any vaccine within the last 14 days?	☐ YES	☐ NO
9. Have you had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	☐ YES	☐ NO
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES	☐ NO
11. Are you considered immunocompromised?	☐ YES	☐ NO
12. FEMALES: Are you pregnant or breastfeeding?	☐ YES	☐ NO

I have been given the Fact Sheet for Recipients &Caregivers and HIPAA. I have read these documents and have no further questions. I understand the risks & benefits & voluntarily consent to receiving the COVID-19 vaccine. I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects & precautions that should be considered prior to getting the vaccine and consent to emergency treatment if needed.

Patient Signature: Date:

Vaccine	*Manufacturer*	*VIS*	*Lot#*	*Exp Date*	*Site/Route*	*Dosage Vol*
SpikeVax 2024-2025	Moderna	10/19/23			LD IM RD IM	0.5 mL

Immunizer Signature: Admin Date:

____ Billed ____ Scanned _____ Faxed PCP ____ PA SIIS