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Moderna Covid-19 Vaccine

COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: ____/____/____	Age:
ADDRESS		SSN ___ ___ ___ - ___ ___ - ___ ___ ___ Email address:	
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
EMERGENCY CONTACT: Name	Relation	Phone Number	

Race: (check only 1)	Ethnicity: (check only 1)	Primary Language:	Gender:
☐ Asian/Polynesian ☐ Black ☐ Multiracial ☐ Native Am/Alaskan ☐ White ☐ Unknown	☐ Not Hispanic ☐ Hispanic ☐ Unknown	☐ English ☐ Other _____	☐ Male ☐ Female

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?	○	○	○
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product and the date administered: ☐ Pfizer _____ ☐ Moderna _____ ☐ Another Product _____	○	○	○
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something: For example, a reaction for which you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital?	○	○	○
*Was the severe reaction after receiving a COVID-19 vaccine?	○	○	○
*Was the severe reaction after receiving another vaccine or another injectable medication?	○	○	○
4. Have you received another vaccine in the last 14 days?	○	○	○
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) 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?	○	○	○
7. Do you have a bleeding disorder or are you taking a blood thinner?	○	○	○
8. Are you pregnant or breastfeeding?	○	○	○

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers (https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf) prior to receiving the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me or the person named for whom I am authorized to make this request.

My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.

_____ _____ X_____

Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	____ml ☐ 1st ____ml ☐ 2nd	☐ IM - L Arm ☐ IM - R Arm					
COVID-19	____ml ☐ 1st ____ml ☐ 2nd	☐ IM - L Arm ☐ IM - R Arm					