COVID-19 Moderna Vaccination

PLEASE PRINT

Patient Last Name:	**First Name**:	**MI**:
Sex: ☐ M ☐ F	**DOB**: / /	**Current Age**:
Address:	**City**: **State**:	**Zip**:
Cell Phone: ( )	**Alternate Phone:** ( )	

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. *If a question is not clear, please ask a healthcare provider to explain.*		
1. Has the person to be vaccinated ever received a COVID-19 vaccine?.....	☐ Yes	☐ No
Date _____ Manufacturer_____		
2. Does the person to be vaccinated have an allergy to a component of the vaccine?.....	☐ Yes	☐ No
Allergies:_____		
3. Has the person to be vaccinated ever had a severe (anaphylaxis) reaction to an injectable or intravenous medication or vaccine?.....(**Defer to RMD**).....	☐ Yes	☐ No
4. Has the person to be vaccinated ever had a severe (anaphylaxis) reaction due to any cause?....(**observe for 30 minutes**).....	☐ Yes	☐ No
5. Is the person to be vaccinated sick today, including symptomatic or asymptomatic infection with COVID-19?.....	☐ Yes	☐ No
6. Has the person to be vaccinated received any vaccine in the past 14 days?.....	☐ Yes	☐ No
7. Has the person to be vaccinated received passive antibody therapy for COVID-19 in the past 90 days?.....	☐ Yes	☐ No
8. Is the person to be vaccinated younger than 18 years old?.....	☐ Yes	☐ No
9. Is the person to be vaccinated pregnant or breastfeeding?.....	☐ Yes	☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and _____ Notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

I hereby release _____, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ DATE: _____

This consent is valid for 12 months from date signed.

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Vaccination Site Location [address]_____

AREA FOR OFFICIAL USE ONLY Nursing Immunization **[INJECTION #1]** Documentation
Manufacturer: Moderna **Dose:** 0.5 mL **Route**: IM **Site Administered:** ☐Right Deltoid ☐Left Deltoid ☐[Other] **Lot Number:** _____ **Expiration Date: / /** **EUA Date:** 12**/**2020 **Date Given: / /** **Provider number:** _____ **Signature:** _____ *Signature indicates immunization given according to PHN Protocol* ☐Vaccine NOT given secondary to contraindication:

AREA FOR OFFICIAL USE ONLY Nursing Immunization **[INJECTION #2]** Documentation
☐All initial screening questions have been reviewed and discussed. **Manufacturer:** Moderna **Dose:** 0.5 mL **Route**: IM **Site Administered:** ☐Right Deltoid ☐Left Deltoid ☐[Other] **Lot Number:** _____ **Expiration Date: / /** **EUA Date:** 12**/**2020 **Date Given: / /** **Provider number:** _____ **Signature:** _____ *Signature indicates immunization given according to PHN Protocol* ☐Vaccine NOT given secondary to contraindication: