COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: ________________________________ **Birth date**: ___/___/_____

IMMUNIZATION SCREENING, QUESTIONNAIRE, & ACKNOWLEDGEMENT – FOR VACCINE RECIPIENT

	Question		
1.	**Is the person to be vaccinated sick today or experiencing a high fever?**	**No**	**Yes**
2.	**Have you ever received a dose of COVID-19 vaccine?** **---If yes, which vaccine product? ☐ Moderna ☐ Pfizer ☐ J&J**	**No**	**Yes**
3.	**Have you ever had an allergic reaction to:**		
■	**A component of a COVID-19 vaccine, including either of the following:**		
■	Polyethylene glycol (PEG); found in some medications, such as laxative & preparations for colonoscopy procedures.	**No**	**Yes**
■	Polysorbate, which is found in some vaccines, film coated tablets and intravenous steroids	**No**	**Yes**
■	A previous dose of COVID-19 vaccine	**No**	**Yes**
4.	**Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?**	**No**	**Yes**
5.	**Are you a male between ages 12 and 29 years old and will be receiving an mRNA (Moderna) COVID vaccine today?** **__________initial, If yes, I have been informed of the risk of developing myocarditis (an inflammation of the heart) Or pericarditis (inflammation of the lining around the heart) after receipt of an mRNA vaccine. Low Risk.**	**No**	**Yes**
6.	**Do you have a history of myocarditis or pericarditis?**	**No**	**Yes**
7.	**Have you had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental, or oral medication allergies?**	**No**	**Yes**
8.	**Have you had COVID-19 and were treated with monoclonal antibodies or convalescent serum?**	**No**	**Yes**
9.	**Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) After a COVID-19 infection?**	**No**	**Yes**
10.	**Do you have a bleeding disorder and/or take a blood thinner?**	**No**	**Yes**
11.	**Do you have a weak immune system (i.e. HIV infection, cancer) or take immunosuppressive drugs or therapies?**	**No**	**Yes**
12.	**Have you received dermal fillers?**	**No**	**Yes**
13.	**Do you have a history of Guillain-Barre Syndrome (GBS)?**	**No**	**Yes**

I have been offered a copy of the Vaccine Information Statement(s) (VIS) and/or Emergency Use Authorization (EUA) Fact Sheet for the vaccine checked below. I have read, had explained to me, and understand the information. I understand and am aware **I am advised to wait for 15 minutes post vaccination for monitoring**. I ask that the vaccine checked below be given to me or to the person named above for whom I am authorized to make this request. ☐ **Moderna, mRNA-1273**

X Client Signature: ____ Date: _______________

Print name if guardian or parent:

FOR CLINIC USE ONLY

Clinic site: ___*Stonecreek Family Physicians*______________________________ ***EUA Fact Sheet Provided***: *(Yes)* *No*

Date vaccine administered: ______*11-06-2021*________ ***Date booster required***: _________*NA*____________________

Vaccine manufacturer: ____*MODERNA*______________________________ ***Lot number***: 051F21A________exp:12/3/21______

Site of IM injection: *RDT or LDT or* __ ***Dose***: *(0.25ml)* *0.5ml* ***Vaccine Administrator***: ______________________________