COVID 19 CONSENT AND VACCINE SCREENING FORM

Patient/Recipient Name	
Date of Birth	/ /

VACCINE CONSENT: I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the Covid 19. I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request and authorize the release of immunization records for the patient below to any school, health department or other healthcare provider. This authorization is effective for one year after the date listed below.

Patient/Recipient Signature:

VACCINE TO BE ADMINISTERED: Moderna Covid 19 Vaccine

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES FOR ADULTS

(As designed by the CDC)

SCREENING QUESTIONS	**YES**	**NO**	**DON'T KNOW**
Are you feeling sick today?			
Have you ever received a dose of Covid 19 vaccine? If Yes which product: ☐ Moderna ☐ Pfizer ☐Other ____________			
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 allergic reaction after receiving another vaccine or another injectable medication?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
Have you received another vaccine in the last 14 days?			
Have you had a positive test for COVID-19 or has a doctor ever told that you had COVID-19?			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breastfeeding?			

Did you bring your immunization record card with you? ☐yes ☐no

It is important for you to have a personal record of your vaccinations. If you don't have a personal record ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Form Reviewed by: ____ Date: __________________