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?.................................... Date ____________________ Manufacturer____	☐ Yes	☐ No
2. Does the person to be vaccinated have an allergy to a component of the vaccine?............... Allergies:____	☐ Yes	☐ No
3. Has the person to be vaccinated ever had a severe (anaphylaxis) reaction to an injectable or intravenous medication or vaccine?...	☐ 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. 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 will be required, 4 weeks apart. 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 Marble City Family Care & Obstetrics, 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/GUARDIAN/POWER OF ATTORNEY SIGNATURE: ________________________________ **DATE:** __________

This consent is valid for 12 months from date signed.