

MODERNA COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ First Middle Last		OCCUPATION _____ Street City State Zip	
Address: _____		Mobile phone: (____) _____ -- _____ Covered by Insurance, Medicaid, or Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth: _____ -- _____ -- _____	Age: _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Primary Language: English <input type="checkbox"/> Other _____ <input type="checkbox"/>
Race: (check only 1) Asian/Polynesian <input type="checkbox"/> Multiracial Native Am/Alaskan <input type="checkbox"/>	Black <input type="checkbox"/> Unknown <input type="checkbox"/>	White <input type="checkbox"/>	Emergency Contact Phone#: _____ Name: _____

Please answer the health questions below:			Yes	No	Unknown
1. Are you sick today or currently in an isolation or quarantine period for COVID-19?					
2. Have you had a positive COVID-19 test in the last 3 months/90 days?					
3. Have you received passive antibody therapy as treatment for COVID-19?					
4. 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?					
5. Have you ever had a serious reaction after receiving a vaccine or another injectable medication?					
6. Have you received any vaccinations in the past two weeks/14 days?					
7. Do you have a bleeding disorder or are you taking a blood thinner?					
8. Do you currently have a weakened immune system, take immunosuppressive medications, or receive radiation or chemotherapy treatment?					
9. Are you pregnant or currently breastfeeding?					
10. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine? ...Pfizer ...Moderna Date received: _____					
<ul style="list-style-type: none"> • I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand the FDA has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction. • I understand this COVID-19 vaccine requires 2 doses given 1 month apart. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the FACT SHEET to complete the vaccination series. I consent to receive call and/or text message reminders at the mobile phone number provided above. • My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with a history of previous anaphylactic reactions, should stay on site for 30 minutes. I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. • An administration fee may be billed to third party payers. I authorize Compass/Lanoi Medical Group to bill any and all third party payers for this service. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein. • I ALLOW my/my child's immunization record to be shared with other health care providers, agencies, or schools in the California Immunization Registry • I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown. I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME OR THE PERSON LISTED ABOVE 					

X _____ Patient or Parent/Guardian Signature Print Name _____ Date _____

OFFICE USE ONLY Record of Immunization OFFICE USE ONLY						
Vaccine	Lot #	Exp Date	Dose	Route – Site	DATE	Provider Signature, Title
PFIZER				... IM LEFT Deltoid ... IM RIGHT Deltoid		