Medical 785-825-7251 | Dental 785-826-9017 | Pharmacy 785-452-3900 | Main Office 785-825-7251

Moderna COVID-19 Vaccine Consent Form

PATIENT INFORMATION				
Patient's **LEGAL** Last Name:	Patient's **LEGAL** First Name:	Phone Number:	Age:	Birthdate:
Street Address:	City:	County:	State:	Zip Code:

Ethnicity: Hispanic or Latino

_____ Yes _____ No

Assigned sex at birth:

_____ Male _____ Female

Race: (Select one or more)

_____ AS-Asian/Pacific Islander/Other
_____ BL-Black or African American
_____ CA-Caucasian (White)/Mexican/Puerto Rican
_____ CH-Chinese
_____ FI-Filipino
_____ HA-Hawaiian
_____ IN-Native American/Alaska Native
_____ JA-Japanese
_____ NW-Other Non-White
_____ UN-Unknown

Insurance Co.:	Insurance ID#:	Group ID#:	Primary Physician:

VACCINATION SCREENING QUESTIONNAIRE	
1. Is the person to be vaccinated currently sick or experiencing a high fever?	☐ Yes ☐ No
2. Has the person to be vaccinated had a serious reaction to a vaccine or other injection in the past?	☐ Yes ☐ No
3. Does the person to be vaccinated have any allergies to medications, food, eggs, gelatin, yeast, latex, Polyethylene glycol, Tromethamine, acetic acid, Sodium acetate, or sucrose? Please list:	☐ Yes ☐ No
4. Has the person to be vaccinated received any other vaccine in the past 14 days? List:	☐ Yes ☐ No
5. Has the person to be vaccinated been diagnosed with COVID-19 in the past 90 days? If yes, did they receive passive antibody therapy or plasma as part of their treatment? ☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 3 months, has this person taken medications that weaken their immune system, such as cortisone, Prednisone, other steroids, or anti-cancer drugs, or had radiation treatments?	☐ Yes ☐ No
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
8. Does the person to be vaccinated have a health problem with lung, heart, kidney, metabolic disease (diabetes), Asthma, a blood or bleeding disorder, or on a blood thinner?	☐ Yes ☐ No
9. Females: Are you breastfeeding?	☐ Yes ☐ No
10. Females: Is the person to be vaccinated pregnant or have a chance of becoming pregnant within the next month?	☐ Yes ☐ No
11. Has the person to be vaccinated received a non-Moderna COVID-19 vaccine? Pfizer or Other: Date:	☐ Yes ☐ No
12. If the person to be vaccinated has received a prior Moderna COVID-19 vaccine, what is the date? Date:	☐ N/A
13. How would like us to remind you about your appointment for your second dose?	☐ Text ☐ Call ☐ Either

Please read and checkmark each of the following statements then sign below.

☐ I have been offered a copy of the Vaccine Fact Sheet EUA use of Moderna COVID-19 vaccine, whether accepted or not, for the vaccine checked below. I have read or had explained to me the information in the Fact Sheet, including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination. I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

☐ *I understand the importance of remaining in the clinic for 15 minutes after I/my child receive this vaccine. I understand that there is an increased risk of allergic reactions and syncopal episodes within the first 15 minutes after a vaccination, and if I/my child choose to leave the facility, I assume responsibility for this risk.*

☐ I attest that the person being vaccinated is eligible for COVID-19 vaccination based on current Kansas Department of Health and Environment guidance.

____ _______________

Signature of Patient or Parent/Guardian **Date**

Staff use only:

VACCINE	*DOSE*	*EXT*	*SITE*	*ROUTE*	*MANUFACTURER LOT #*	*EXP DATE*
COVID-19	**0.5 ml.** **1 2**	**RT LT**	**Deltoid** **Vastus Lat**	**IM**	**Moderna**	

Signature and Title of Vaccine Administrator _______________________________ **Date Given** ____________