COVID – 19 Vaccine Acknowledgement and Consent Form

Moderna COVID–19 Vaccine FIRST DOSE

Recipient Information (Please Print Clearly)

Last Name:	**First Name:**	**Date of Birth:**
Home Address:		**Phone #:**
City:	**State:**	**Zip:**
Ethnicity: **☐ Black/African-American ☐ Caucasian ☐ Asian ☐ Native-American ☐ Other:**		

The following questions will help us determine whether you can receive the COVID–19 vaccine. If you answer 'yes' to any question, it does not necessarily mean that you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask a staff member for further explanation:

	YES	NO	N/A
Are you sick today?	☐	☐	☐
Do you have a history of severe allergies?	☐	☐	☐
Have you ever had a serious reaction after receiving a vaccination, including the first dose of the COVID-19 vaccine?	☐	☐	☐
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?	☐	☐	☐
Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
Do you have a bleeding disorder or are you on a blood thinner?	☐	☐	☐
Are you immunocompromised or on a medication that affects your immune system?	☐	☐	☐
For Women: Are you pregnant or planning to become pregnant?	☐	☐	☐
For Women: Are you breastfeeding?	☐	☐	☐
Have you received any vaccinations (other than the first dose of the COVID-19 vaccination) in the past 2 weeks?	☐	☐	☐
Have you previously been diagnosed with COVID-19 and were treated with monoclonal antibodies in the last 90 days?	☐	☐	☐

I understand that the COVID-19 vaccine I will receive today requires two (2) doses from the same manufacturer to be fully effective. I understand I must return in 28 days to receive a second dose of the vaccine.

I consent to administration of the Moderna COVID-19 vaccination and acknowledge and agree with the following statements:

Initial before each statement (or put N/A if not applicable)

- ___ I have received the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine (the 'Fact Sheet').
- ___ I have read the 'Fact Sheet' or had it read to me.
- ___ The U.S. Food and Drug Administration (FDA) has authorized emergency use of the Moderna COVID-19 vaccine, which is not an FDA-approved vaccine. At this time, there is no FDA approved vaccine to prevent COVID-19.
- ___ I understand the known and potential risks and benefits to this COVID-19 vaccine and the extent to which such benefits and risks are unknown.
- ___ I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to this COVID-19 vaccine and the risks and benefits of available alternatives.
- ___ Recipients who are Pregnant or Breastfeeding: Pregnant and breast feeding persons were NOT included in the clinical trials for the COVID-19 vaccine. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive the COVID-19 vaccine.
- ___ I understand that it is recommended that I remain at the vaccination clinic for fifteen (15) minutes following administration, but those with history of anaphylaxis should be monitored for thirty (30) minutes post vaccination to ensure that I have no immediate adverse reaction to the vaccine.
- ___ I acknowledge that I have received information on V-Safe, a voluntary smartphone based tool operated by the Centers for Disease Control and Prevention (CDC). Through V-Safe, vaccine recipients can report any side effects of the vaccine to the CDC. This information helps CDC monitor the safety of the COVID-19 Vaccines in near real time.
- ___ I have had the opportunity to ask questions regarding the administration of the Moderna COVID-19 vaccination which have been answered to my satisfaction.

If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or present to the nearest emergency department. If you are experiencing a medical emergency, call 911.

Signature of Recipient/Authorized Representative:	**Date:**
Print:	
If signed by Authorized Representative, please state relationship to Recipient:	

FOR CLINIC USE ONLY

Patient Name:	**Date of Birth:**
Vaccine Administrator (Print Name):	
Administration Date:	**Date Fact Sheet Provided:**
Scheduled date of 2nd vaccination:	

Manufacturer	Lot Number	Expiration Date	Site of Administration
			☐ Left Arm ☐ Right Arm

☐ Monitoring period completed and no adverse reaction noted.
☐ Recipient declined monitoring period. Waiver Completed.

☐ Adverse reaction noted:
_____

Signature of Observer: _____

The COVID-19 Acknowledgement and Consent Form and COVID-19 Post-Vaccination Monitoring Period Waiver (if applicable) must be uploaded to the patient/employee chart.