COVID-19 Vaccine Screening and Consent Form

Patients' Last Name:_____ First Name:_____ DOB:_____

Please delay vaccination if you presently have COVID-19 or if you have any symptoms of COVID-19 suspected or confirmed.

COVID-19 Screening Questions

Has your child ever received a COVID-19 vaccine? Yes No

If yes, which one? Johnson and Johnson Moderna Pfizer-BioNTech

Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Yes No

Is your child feeling sick today? Yes No

Has your child tested positive for COVID-19 in the last 90 days? Yes No

Has your child ever had a severe allergic reaction to any of the following?

(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused a visit to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

- Has the patient ever had an allergic reaction to another vaccine (other than COVID-19) or an injectable medication? Yes No
- Has the patient ever had an allergic reaction to any component of the COVID-19 vaccine, including polyethylene glycol (PEG) which is found in some medications, such as laxatives and preparations for colonoscopy procedures? Yes No
- Has the patient ever had an allergic reaction to Polysorbate? Yes No
- Has the patient had an allergic reaction to a previous dose of COVID-19 vaccine? Yes No

If yes, please explain?_____

Consent for Vaccination

I have been given and have read or have had explained to me, the information in the "Fact Sheet For Recipients And Caregivers" (https://eua.modernatx.com/covid19vaccine-eua/6m-5y-facts-recipient.pdf). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to my child, or the person named for whom I am authorized to make this request.

__ I have understood the information provided to me about the COVID-19 vaccine.
___I am aware of the possible side effects.
___I have had a chance to ask any questions.
___I consent to receive the COVID-19 vaccine.
___I consent to billing my insurance for any administration fees.
___I am aware I must wait a minimum of 15 minutes after vaccination. (If known allergic reaction 30 minutes)
___I have been provided post vaccination instructions.

Print Name:_____ Sign:_____ Date:_____

Clinic Use Only:		
Product: MODERNA	Lot#:	
Site:	Administered By:	Date: