

Moderna Covid-19 Vaccine COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)				(First)			Date of Birth:				Age:				
									_/=		-				
ADDR	ESS														
CITY		OT A													
				ZIP	IP DAY			TIME PHONE NUMBER							
EMERGENCY CONTACT: Name Relation Pho									one Number						
Race:	(check only	<u> </u>			Ethnicity: (c	heck or	aby 1)	Drima	es. T	anguag	۵.	C	ender:		
□Asian/Polynesian □Black					Ethnicity: (check only 1) Not Hispanic				Primary Language: ☐ English				□Male		
□Multiracial □Native Am/Alaskan					☐ Hispanic ☐ Unknown			Other							
□White □Unknown					- I - I - I - I - I - I - I - I - I - I				<i>"</i>						
		Please ans	wer the h	ealt	h auestions b	elow.				Yes	N		Do Not		
Please answer the health questions below:									ics			Know			
	ou feeling sick									-					
2. Have	you ever receiv	red a dose of	COVID-19) vac	cine?										
*If yes, which vaccine product and the date administered: □ Pfizer															
	Aoderna														
	Moderna Another Product	L													
3. Have	von ever had a	severe allero	ric reaction	(0.0	, anaphylaxis) t	o namoti	hina. E.	1							
reaction	for which you	were treated	with Epine	(c.g. phrii	ne or EpiPen, or	for which	ning. re ch vou	had to go	e, a						
the hospi	ital?						-								
	the severe react														
*Was t	the severe react	ion after rec	eiving anot	her v	accine or anoth	er inject	able me	edication?							
	you received an														
as treatm	ent for COVID	-19?			noclonal antiboo				n)						
6. Do you	u have a weake	ned immune	system car	ısed	by something s	ıch as H	IV infe	ction or							
cancer or	do you take in	nmunosuppr	essive drug	s or i	therapies?							_			
				aking	g a blood thinne	r?						1			
8. Are yo	ou pregnant or b	preastfeeding	<u>5?</u>												
I have bee		. 11	1.1 77		WY 4 .9 Y										
and Cares	en given a copy givers (https://w	and nave rea	d the Emerg	ency d10v	Use Authorizat	on (EUA	(and r	eviewed th	ne FD	A Fact Sh	eet fo	or Ro	ecipients		
vaccine. I	have had the ch	nance to ask	uestions that	at we	re answered to n	iv satisfa	ection. I	understan	d the	henefits a	nd ris	co sks r	of the		
vaccine in	ndicated and ask	that it be giv	en to me or	the j	person named for	whom l	am aut	horized to	make	this requ	est.	,,,,,,			
N	My signature ac	cknowledges	that I was	advi	sed to remain o	a site for	r 15 mi	nutes afte	r rece	iving the	vacc	ine.			
		Those wit	h previous	anap	hylactic reactio	ns shoul	d stay	for 30 min	utes.						
Date Print Name X Patient or Parent/Gu															
	MINISTRATI						ratie	nt or Pare	ent/Gu	ardian S	igna	ture			
Vaccine	Dose	Route	L Y Date Dos	e	Vaccine	Lot Num	ber I	Expiration	1	Name of V	arrina	Active	inistrator		
			Administe	red	Manufacturer		_	Date		1-11110 01 1		WANTE	-1.1.3£1 4,Ø1		
OVID-19	ml 🗆 2 nd	IM - L Arm IM - R Arm													
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