COVID-19 Moderna Bivalent Vaccine **BOOSTER** Consent/Record Vaccine Recipient Information

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**Last First M.I.**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City State Zip code**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ Gender: Male Female**

**Phone Number: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary/Family Physician Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Consent I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information. Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of

COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider Use Only**

**Date Vaccine BOOST Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection Site (Deltoid):  Left  Right**

**MFG/LOT#**

**Administered by Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date entered in IRIS: \_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated**. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

**Don’t**

**YES NO Know**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | **Are you feeling sick today**? |  |  |  |
| 2 | **Have you ever received a dose of COVID-19 vaccine**?  ***If YES, which vaccine product?***  MODERNA PFIZER Johnson & Johnson Another Product  **How many doses of COVID-19 have you received**? \_\_\_\_\_\_\_\_\_  **Did you bring your vaccination record card or other documentation?** | \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_ |  |  |
| 3 | **Have you ever had an allergic reaction to another vaccine** (other than COVID-19 vaccine) **or an injectable medication**?  This would include a severe reaction for which you were treated with epinephrine or EpiPen, or caused you to go to the hospital? It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) |  |  |  |
| 4 | *\*\*\** ***Check all that apply*** *\*\*\** |  |  |  |
|  | Have a history of myocarditis or pericarditis |  |  |  |
|  | Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19 |  |  |  |
|  | Diagnosed with Multi-system Inflammatory Syndrome  (MIS-C OR MIS-A) after a covid |  |  |  |
|  | Have a Bleeding Disorder or take a blood thinner |  |  |  |
|  | Have a history of heparin-induced thrombocytopenia (HIT) |  |  |  |
|  | Am currently pregnant or breast feeding |  |  |  |
|  | Have received dermal fillers |  |  |  |
|  | History of Guillain-Barre Syndrome (GBS) |  |  |  |

***9.7.22 Office Use Only:* *Form Reviewed by***  Initials: \_\_\_\_\_\_