

# Northeast Health District: Moderna COVID-19 Vaccine Consent Form

HN2 Site for Data Entry: _____	Client Birthdate: _____
Date of Service: _____	Client ID #: _____
Highest Trained Provider: _____	Additional Providers: _____
<b>Responsible Person Info:</b>	
<i>(for clients under age 18)</i>	
Last Name: _____	First Name: _____
Race: _____	Sex: _____ Birthdate: _____
Relationship: _____ Phone: _____	
Financial Eligibility: A = Native American / Alaskan Native N = No Insurance M = Insured/Vaccines Covered	
COVID-19 vaccine series number: _____	Circle one: 1 <sup>st</sup> dose, 2 <sup>nd</sup> dose, Additional, or Booster Dose
Imm. Up to Date for Age after Visit: _____	Y = Yes N = No
Interval to Next Imm: _____ (days/weeks/months)	
VIS Names: Moderna COVID-19 Fact Sheet for Recipients	

Data Entry to Complete	Initials
HN2 Client Register; Insurance; Signature	
HN2 Encounter	

## Section 1: Information about Patient to Receive COVID-19 Vaccine *(please print)*

PATIENT NAME (Last) If applicable, Suffix	(First)	(M.I.)	PATIENT'S MAIDEN NAME	COUNTY OF RESIDENCE
PATIENT BIRTHDATE (mm/dd/yyyy)	PATIENT AGE	GENDER Male Female	Mother's Maiden Last Name for GRITS	
ETHNICITY <i>(Please Circle)</i> Not Hispanic/Latino Hispanic Latino	RACE <i>(Please Circle)</i> Asian Black White Multi-racial Native American/Alaska Native Native Hawaiian/Other Pacific Islander		MARITAL STATUS <i>(Please circle)</i> Single Married Divorced Separated Widowed	
MAILING ADDRESS			PHONE NUMBER (home, mobile, work)	
CITY	STATE	ZIP CODE	E-MAIL (personal, work)	
EMERGENCY CONTACT PERSON		RELATIONSHIP	PHONE NUMBER FOR EMERGENCY CONTACT	

## Section 2: Medical Information: *The following questions will help us to determine if this person can receive the COVID-19 vaccine.*

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> Novavax <input type="checkbox"/> Other: _____			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing? *Was the severe reaction after receiving a COVID-19 vaccine? *Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Check all that apply to you: <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Have a history of Guillain-Barre Syndrome <input type="checkbox"/> Have a bleeding disorder or take blood thinners <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection			
5. Check all that apply to you: <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____ <input type="checkbox"/> Take immunosuppressive drugs or therapies: If yes, please list: _____			

## Section 3: CONSENT: *If this consent form is not filled in completely, signed and dated, the patient will not be vaccinated.*

**I GIVE CONSENT** to DPH District 10 for the patient named above to receive the COVID-19 vaccine. I acknowledge that the patient and medical information provided above is correct. I have been given a copy of and have read (or have had explained to me) the information in the Moderna COVID-19 Fact Sheet for Recipients and Caregivers. I have been given an opportunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and request it be given to me or to the patient named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 15 minutes at the clinical site after receiving the immunization in case of a reaction to the vaccine.

**Patient/Guardian Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

HN2 Code	Vaccine Description	Source	Age Range	Dosage (Circle one)	NDC	Lot #	Site	
							LD	RD
COVID-19-MODERNA-S	Moderna COVID-19 Vaccine (mRNA; LNP-S, pres-free; 100 mcg/0.5mL; MDV)	StSupl	> = 12 years	0.5 mL 1st, 2nd, Additional	80777-0273-99		LD	RD
							Intramuscular	
COVID-19-MODERNA-BS	Moderna COVID-19 Vaccine Low Dose BOOSTER (mRNA; LNP-S, pres-free; 50 mcg/0.25mL; MDV)	StSupl	> = 18 years	0.25 mL Booster	80777-0273-99		LD	RD
							Intramuscular	
COVID-19-MODERNA-PED-S	Moderna COVID-19 Vaccine - PEDIATRIC, Age 6Y-11Y (mRNA; LNP-S, pres-free; 50 mcg/0.50mL)	StSupl	6Y-11Y	0.5 mL 1st, 2nd, Additional	80777-0275-99		LD	RD
							Intramuscular	
COVID-19-MODERNA-PED-6MO-S	Moderna COVID-19 Vaccine - PEDIATRIC, Age 6MO-5Y (mRNA; LNP-S, pres-free; 25 mcg/0.25mL)	StSupl	6M-5Y	0.25 mL 1st, 2nd, Additional	80777-0279-99		LD	RD
							Intramuscular	