Spencer Hospital
Clay County Public Health
Healthier Together.

Moderna COVID-19 Vaccine Screening & Consent

☐ 1st Dose ☐ 2nd Dose ☐ Additional or Booster Dose

Name: _____ Date of Birth: _____ Gender: ☐Female ☐ Male

Maiden Name: _____ Phone Number: _____

Address: _____City: _____State: _____ Zip: _____

Medical Provider: _____ Emergency Contact/Phone #: _____

Please answer the questions below. If you answer 'yes' to any questions, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

1. Are you feeling sick today? ☐ Yes ☐ No ☐ Don't Know

   - Have you received a COVID-19 vaccine previously? ☐ Yes ☐ No ☐ Don't Know
   - If yes: Which vaccine? ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other
   - How many doses of COVID-19 vaccine have you received? _____

2. Have you ever had a severe allergic reaction (anaphylaxis) to something that required treatment with epinephrine or EpiPen or required hospitalization? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No ☐ Don't Know
   - Was this severe allergic reaction after receiving another vaccine or injectable medication? ☐ Yes ☐ No ☐ Don't Know

3. Check all that apply to you:
   - ☐ Am a female between ages 18 and 29 years old
   - ☐ Am a male between ages 12 and 29 years old
   - ☐ Have a history of myocarditis or pericarditis
   - ☐ Had a severe allergic reaction to something other than a vaccine such as food, pet, venom, environmental or oral medication allergies
   - ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Have a weakened immune system (i.e. HIV infection, cancer)
   - ☐ Take immunosuppressive drugs or therapies
   - ☐ Have a bleeding disorder
   - ☐ Take a blood thinner
   - ☐ Have a history of heparin-induced thrombocytopenia (HIT)
   - ☐ Am currently pregnant or breastfeeding
   - ☐ Have received dermal fillers
   - ☐ History of Guillain-Barre Syndrome (GBS)

Vaccination Release

You are being offered either SPIKEVAX (COVID-19 Vaccine, mRNA) or the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARSCoV-2. I have read or have had explained to me the information in the **FACT SHEET FOR RECIPIENTS AND CAREGIVERS-ABOUT SPIKEVAX (COVID-19 VACCINE, mRNA) AND THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER.** 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 consent to the vaccine be given to me or to the person for whom I am authorized to make this request.

Printed name: _____ Signature: _____ Date: _____

**********For Office Use Only**********

Date:	Manufacturer	Lot #	Exp Date	EUA Fact Sheet	Dose	Site	Adm By	IRIS date/initial
	Moderna			1/31/2022	0.25ml 0.5 ml	R Deltoid L Deltoid		