MODERNA COVID19 VACCINE PRESCREENING AND CONSENT

NAME:_____ **DATE OF BIRTH:** _____

Is this your:

☐ **1st Covid19 Vaccine**

☐ **2nd Covid19 Vaccine** | Date of Last Covid19 Vaccine: _____

Did you receive your Moderna Covid19 vaccine 28 days ago (+/- 4days)?

☐ Yes ☐ No

Are you currently or in the past 14 days been sick with fever, chills, cough or other symptoms?	YES	NO
*Have you been diagnosed with COVID19 infection in the past 90 days?	YES	NO
*Have you received Monoclonal Antibodies or Convalescent Plasma in the past 90 days?	YES	NO
Have you received any other vaccinations within the last 14 days?	YES	NO
Are you currently Pregnant?	YES	NO
Are you currently Breastfeeding?	YES	NO
Are you immunocompromised, have HIV or AIDS, receiving treatment with immune suppressive drugs like steroid, chemotherapy, rheumatological drugs?	YES	NO
Do you have history of severe (life threatening) allergic reaction, Anaphylaxis, to any **vaccine**? If yes, please describe:	YES	NO
Do you have history of severe (life threatening) allergic reaction, Anaphylaxis, to any **medicines**? If yes, please describe:	YES	NO
Do you have history of severe (life threatening) **allergies** to anything else? Ex: Insects, Food etc. If yes, please describe:	YES	NO
Are you allergic to any components of the Moderna covid19 vaccine? Lipid, Polyethylene glycol [PEG], Dimyristoyl glycerol [DMG], cholesterol, Acetic acid, Sodium acetate, Sucrose, 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), Tromethamine, Tromethamine Hcl.	YES	NO

**If you answered "Yes" to this question, the CDC recommends you wait for 90 days from your Covid19 infection, monoclonal antibody treatment or convalescent plasma treatment before getting the Covid19 vaccine*

MODERNA COVID19 VACCINE PRESCREENING AND CONSENT

NAME:_____ **DATE OF BIRTH:** _____

I declare that the information I have provided in this pre-screening & consent form is correct.

I acknowledge that The Food and Drug Administration (FDA) has recently issued an Emergency Use Authorization for the vaccine, mRNA COVID-19 by Moderna. I understand that Pandya Medical Center is administering this vaccine under the recommendation and guidance of Georgia Department of Public Health and the CDC. I have received the FDA fact sheet on this vaccine, which informs me of the significant known and potential risks and benefits of emergency use of this vaccine as well as potential alternatives, their risks and benefits. I acknowledge that I need to obtain two doses of this vaccine within the recommended timeframe and it is my responsibility to ensure proper scheduling. I understand that I have the option to accept or decline this vaccine.

By signing this form, on behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Pandya Medical Center Inc. and its staff, associates, successors, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the Moderna mRNA COVID-19 vaccine. I acknowledge that no warranty, guarantee or assurance has been made to me concerning the results that may be obtained from the administration of this vaccine(s).

I authorize Pandya Medical Center or its agents to submit a claim to my insurance provider or Medicare. I assign and request payment of authorized benefits be made on my behalf to Pandya Medical Center. I acknowledge and authorize Pandya Medical Center to submit my vaccination information to the State of Georgia.

I consent to and authorize Pandya Medical Center, through its designated agents or representatives, to administer the Moderna mRNA COVID-19 vaccine as indicated below. I am giving my full consent to get the vaccine of my own will.

_____ _____

Signature **Date**