MIDWEST REGIONAL HEALTH SERVICES
Let our FAMILY care for yours

MIDWEST REGIONAL HEALTH SERVICES
COVID-19 VACCINE (MODERNA) CONSENT FORM
2020-2021

LAST NAME FIRST NAME MI DOB

ADDRESS CITY STATE ZIP CODE

PHONE NUMBER EMAIL ADDRESS SEX: [ ] M [ ]F

RACE:
[ ] White [ ]Black [ ] Asian [ ] Amer. Indian/ Alaska Native [ ] Other

ETHNICITY
[ ] Hispanic [ ] Non-Hispanic

1. HAVE YOU EVER RECEIVED A COVID-19 VACCINATION? YES NO
2. HAVE YOU RECEIVED ANY VACCINES IN THE PAST 14 DAYS? YES NO
3. DO YOU FEEL SICK TODAY OR HAVE A FEVER? YES NO
4. HAVE YOU EVER HAD A ***SEVERE*** REACTION TO ANY VACCINE? YES NO
   ***IF YES, PLEASE EXPLAIN: ____
5. HAVE YOU EVER HAD AN ANAPHYLACTIC REACTION? YES NO
   DO YOU ROUTINELY CARRY AN EPI PEN? YES NO
6. ARE YOU PREGNANT OR BREAST FEEDING? YES NO
7. HAVE YOU EVER HAD A REACTION TO LATEX? YES NO
8. DO YOU HAVE A BLOOD CLOTTING DISORDER AND/OR TAKE ANTICOAGULANT MEDICATION, WHICH MAY RESULT IN INCREASED BRUISING? YES NO
9. IN THE LAST 90 DAYS HAVE YOU RECEIVED PASSIVE ANTIBODY THERAPY (MONOCLONALANTIBODIES OR CONYALESCENT PLASMA) AS PART OF COVID-19 TREATMENT? YES NO

CONSENT: *I have been given the opportunity to ask questions and I understand the benefits and risks associated with this vaccine. I give my consent to the staff at Midwest Regional Health Services to administer the vaccine indicated.*

Signature ____ Date: ____________________

FOR PERSONNEL USE ONLY

MANUFACTURER: MODERNA DOSE: 0.5mL ROUTE: IM Lot#: *Expires:*

SITE: (Please Circle) Right Deltoid Left Deltoid

SCREENED BY: ____ *DATE:* ______________________

ADMINISTERED BY: ____________________________________ *DATE:* ______________________