Moderna Documentation/Consent Form

Patient Information (Please print legibly)

Last Name: _____ **First Name:** _____ **Middle:** _____
Date of Birth: _____ **Age:** _____ **Sex:** ☐Female ☐Male
Address: _____
City: _____ **State:** _____ **County:** _____ **Zip:** _____
Phone: _____ **Insurance Carrier:** _____
Policy Number: _____ **Name on Insurance card**: _____

Race: (Mark all that apply) ☐***Caucasian/Mexican/Puerto Rican*** ☐***Black/African American*** ☐***American Indian/ Alaska Native*** ☐***Asian*** ☐***Native Hawaiian/Pacific Islander*** ☐***Japanese*** ☐***Chinese*** ☐***Filipino*** ☐***Non-White*** ☐ ***Unknown- Prefer not to say***
Hispanic/Latino: ☐*Yes* ☐*No*

Screening Questionnaire

COVID-19 Screening Questions

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?.....☐*Yes* ☐*No*
2. Do you have a fever greater than 100.4 today?.....☐*Yes* ☐*No*
3. Do you have any allergies to any of the following components?
4. **MODERNA:** messenger ribonucleic acid, lipids (SM-102, polyethylene glucol 2000 dimyristoyl glycerol, cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine), tromethamine, thromethamine hydrocholoride, acetic acid, sodium acetate, and/or sucrose?.....☐*Yes* ☐*No*
5. Have you had a serious reaction to any vaccine in the past? _____☐*Yes* ☐*No*
6. Are you pregnant?.....☐*Yes* ☐*No*
7. Have you taken steroids in the last 21 days? _____ ☐*Yes* ☐*No*
8. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?.....☐*Yes* ☐*No*
9. Have you received a COVID-19 injection? _____ ☐*Yes* ☐*No*
10. Have you received monoclonal antibodies or convalescent plasma as treatment for COVID-19 in the past 90 days? .....☐*Yes* ☐*No*
11. I currently DO NOT have health insurance, Medicare, Medicaid. Initial _____

I have been offered a copy of the COVID-19 Emergency Use Authorization (EUA). **I have read and understand the information in the EUA.** I ask that the injection be administered to me. I consent to inclusion of this data in the Kansas Immunization Information System (KSWebIZ) for myself.
I agree to wait 15 minutes after receiving the injection. I understand that this medication is not FDA-approved. I agree to have CCHD bill my insurance for the administration fee.
I understand that the common risks associated with the COVID-19 injection include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the injection may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body,

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dizziness and/or weakness). I understand that myocarditis, pericarditis and Antibody-Dependent Enhancement may occur following this injection. I understand that these may not be all the side effects of the COVID-19 injection as the injection is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the injection. I understand that the long-term side effects or complications of this injection are not known at this time.

I understand that the risks of the injection are unknown and have not been studied in persons with the following health conditions or treatments: breastfeeding, seeking pregnancy, autoimmune conditions, immunosuppressing medications, recent blood transfusions, recent immune therapy treatments, recent antiviral drug treatment, long-term health problems (heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, anemia, or other blood disorder), history of Guillain-Barre syndrome, bleeding disorders or blood thinners.

I understand that the medication is being given by Coffey County Health Department (CCHD). The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the injection. My consent is given in light of this knowledge, and in consideration of (CCHD) giving the COVID-19 injection. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless of Coffey County Health Department, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 injection. Coffey County Health Department makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the injection or its effectiveness. I acknowledge receipt of CCHD's Notice of Privacy Practices.

_____ _____

Signature of Patient *Date*

_____ _____

Printed Name of Patient *Date of Birth*

For Office Use Only

☐ **Moderna** **Lot #** **Exp**

Site: Deltoid ☐ *Left* ☐*Right* **Dose:** 1 2 3

Administered By: _____ **Date:** _____

Signature and Title

Revised 10.26.2021

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