COVID-19 Vaccination Screening & Consent Form

The following questions will help determine if there is reason you should not receive the COVID-19 vaccine today. A "yes" answer does not mean you should not be vaccinated; only that additional questions must be asked. If yes to any question, please consult with your healthcare provider.

	Yes	No	Unknown
Have you tested positive for COVID-19 in the past 14 days?	☐	☐	☐
Do you have a weakened immune system caused by, HIV infection, cancer, or immunosuppressive drugs?	☐	☐	☐
Do you have a bleeding disorder or are you taking blood thinners?	☐	☐	☐
Have you had a vaccine in the past 2 weeks?	☐	☐	☐
Are you sick today?	☐	☐	☐
Do you have an allergy to a component of the vaccine?	☐	☐	☐

Messenger ribonucleic acid (mRNA), lipids polyethylene glycol 2000 dimyristoyl glycerol, cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. (hives, itching, difficulty breathing)

Have you EVER had anaphylaxis NOT related to an injection? (severe, potentially life-threatening allergic reaction)	☐	☐	☐
For females only: Could you be pregnant or are you breastfeeding?	☐	☐	N/A

I know the Food and Drug Administration (FDA) has authorized emergency use of this vaccine and that it is not a fully licensed FDA vaccine. I know I must get two doses and receive the same vaccine each time. I have been given information specific to the Moderna COVID-19 vaccine and have been able to ask questions to my satisfaction. I understand the benefits, risks, and elect to receive the vaccine. Vaccine administration will be reported via Washington Immunization Information System.

Name: _____ DOB: _____
Please Print

Address: _____ Phone: _____

_____

Signature: _____ Date: _____

Authorized Medical Staff Only:

_____ I have reviewed the information provided above.

Vaccination Date: _____ Time: _____ Injection Site: (IM Deltoid) L ___ R ___

Vaccine Lot #_____ Expiration Date: _____

Provider Signature: _____