



Administration Facility Name/Facility ID: \_\_\_\_\_

## COVID-19 VACCINE SCREENING AND CONSENT FORM

### Moderna COVID-19 Vaccine

**SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)**

<b>Name:</b> Last: _____ First: _____ Middle Initial: _____							
<b>Date of Birth:</b> Month _____ Day _____ Year _____	<b>Mobile Phone Number (Patient or Guardian):</b> (    ) _____						
<b>Address:</b> _____ <b>Apt/Room #:</b> _____							
<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____							
<b>Sex</b> (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;"><b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American</td> <td style="width: 33%;"><input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White</td> <td style="width: 33%;"><input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander</td> </tr> <tr> <td colspan="3"><b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown</td> </tr> </table>	<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
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<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown							
<b>Primary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____							
<b>Secondary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____							
<b>Is this the patient's first or second dose of the COVID-19 vaccination?</b> <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose							

**SECTION 2: COVID-19 SCREENING QUESTIONS**

Please check YES or No for each question.	Yes	No
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		

**SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE**

Please check YES or No for each question.	Yes	No
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only

authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), and their staff, agents, successors, divisions, affiliates, subsidiaries, 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 vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

**Signature of Patient or Authorized Representative** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Representative and Relationship to Person Receiving Vaccine:** \_\_\_\_\_

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

<b>Administered at location: facility name/ID</b>	
<b>Administered at location: Type</b>	
<b>Administration Address:</b>	
<b>CVX (product)</b>	
<b>Sending organization:</b>	

**Vaccinator Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Vaccine administering provider suffix:** \_\_\_\_\_