COVID-19 VACCINE DOCUMENTATION / CONSENT FORM

VACCINE CONSENT: I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the vaccine checked below. I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request and authorize the release of immunization records for the patient below to any school, health department or other healthcare provider. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

By signing below you agree to all information provided in the first four sections of this form.

☐ Moderna COVID-19 Vaccine

Signature of Patient/Patient Representative **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

IMMUNIZATION SCREENING QUESTIONAIRE

1.	Are you feeling sick today?		Yes	No
2.	Have you ever received a dose of COVID-19 Vaccine?	If yes, which product? □ Pfizer □ Moderna □ Other Product _____	Yes	No
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		Yes	No
4.	• Was the severe allergic reaction after receiving a COVID-19 vaccine?		Yes	No
5.	• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		Yes	No
6.	Do you have a bleeding disorder or are you taking a blood thinner?		Yes	No
7.	Have you received passive antibody therapy as treatment for COVID-19?		Yes	No
8.	Have you received any other vaccines in the past 14 days? (Influenza, MMR, etc)		Yes	No

PATIENT INFORMATION

Last Name: _____ First Name: _____

Birth Date: _____ Gender: ☐ Female ☐ Male

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: _____

PARENT/GUARANTOR INFORMATION (Required if patient is under 18 or patient is not guarantor)

Last Name: _____ First Name: _____ Birth Date: _____

Street Address: _____ City: _____

County: _____ State: _____ Zip Code: _____ Phone: _____

VACCINE	MVX	CVX	LOT #	EXP DATE	DOSE
☐ Moderna, COVID-19 Vaccine, 100mcg/0.5mL	MOD	207			☐ 1st Dose ☐ 2nd Dose

DATE	TIME	EXT	SITE	ROUTE	PATIENT LABEL
		☐ Right ☐ Left	☐ Deltoid (*Preferred*) ☐ Vastus Lateralis	Intramuscular (IM)	

Signature & Title of Vaccine Administrator **Date**

Mowery Clinic, LLC