Moderna Monovalent COVID-19 Vaccine (Primary Series)
Moderna Bivalent COVID-19 Vaccine (Booster Dose)
Consent Form

Facility: _____ (The Facility)

Section 1: Personal Information (please print or affix patient sticker)

NAME (Last)	(First)	(M.I.)
DATE OF BIRTH: month_____ day_____ year _____		
PHONE NUMBER	**SEX ASSIGNED AT BIRTH M / F**	

Affix patient sticker here.

PRIMARY VACCINATION SERIES SCREENING – Moderna Monovalent COVID-19 Vaccine ***Complete this section only if you are seeking a primary vaccine dose – proceed to Section 3 for booster doses***			
Section 2: Screening for Vaccine Eligibility – Primary Vaccination Series	**YES**	**NO**	**N/A**
1. Have you had a severe allergic reaction after receiving a previous dose of an mRNA (Pfizer-BioNTech or Moderna) COVID-19 vaccine?	☐	☐	☐
2. Have you had an intermediate or severe allergic reaction to any ingredient in the Moderna COVID-19 vaccine or to polysorbate? *Components of the Moderna COVID-19 Vaccine: nucleoside-modified messenger RNA (mRNA) encoding the pre-fusion stabilized Spike glycoprotein (S) of SARS-CoV-2 virus, lipids, polyethylene glycol [PEG], tromethamine, acetic acid, sodium acetate, and sucrose*	☐	☐	
3. Are you below the minimum age requirement (6 months) for receiving the Moderna COVID-19 vaccine?	☐	☐	
4. For primary series vaccine doses*, have you received a previous COVID-19 vaccine made by a different manufacturer? Your initial doses should be made by the same manufacturer. ** 18 years of age and older: 2 doses, 3 doses for immunocompromised people* ** 6 months to 17 years of age: 2 doses, 3 doses for immunocompromised people*	☐	☐	☐
5. Are you moderately or severely immunocompromised? (see details on page 2) If yes, you are eligible for a third vaccine dose, to be given at least 28 days after your second dose.	☐	☐	

For the first 4 questions, if 'no' or 'N/A' answers, progress to Section 4. For 'yes' answers, please seek guidance.

BOOSTER VACCINATION SCREENING – Moderna Bivalent COVID-19 Vaccine (Booster) – 6 Months of Age and Older ***Complete this section only if you have completed a primary vaccine series and are seeking a booster dose***			
Section 3: Screening for Vaccine Eligibility – Booster Dose	**YES**	**NO**	**N/A**
1. Have you had a severe allergic reaction after receiving a previous dose of an mRNA (Pfizer-BioNTech or Moderna) COVID-19 vaccine?	☐	☐	☐
2. Have you had an intermediate or severe allergic reaction to any ingredient in the Moderna COVID-19 vaccine or to polysorbate? *Components of the Moderna COVID-19 Vaccine: nucleoside-modified messenger RNA (mRNA) encoding the pre-fusion stabilized Spike glycoprotein (S) of SARS-CoV-2 virus, lipids, polyethylene glycol [PEG], dimyristol glycerol [DMG], tromethamine, acetic acid, sodium acetate, and sucrose*	☐	☐	
3. Are you below the minimum age requirement (6 months) for receiving the Moderna COVID-19 bivalent vaccine (booster vaccine)?	☐	☐	
4. Have you completed (2 months since last dose) a primary vaccine series with the Pfizer-BioNTech COVID-19 vaccine*, Moderna COVID-19 vaccine, Janssen COVID-19 vaccine, or Novavax COVID-19 vaccine? * Note: children 6 months to 4 years of age who previously received a 3 dose primary series with the Pfizer-BioNTech vaccine are not eligible to receive the Moderna bivalent booster. The Moderna booster for children 6 months to 4 years of age is only authorized for children who completed a Moderna primary vaccine series. If yes, the Centers for Disease Control and Prevention (CDC) recommends a COVID-19 bivalent vaccine booster shot for you. The booster should be given at least 2 months after either the last dose of the primary series or from the most recent booster dose with any authorized or approved monovalent COVID-19 vaccine.	☐	☐	☐

For the first 3 questions, if 'no' or 'N/A' answers, progress to Section 4. For 'yes' answers, please seek guidance.

Section 4: Consent for Vaccination

- I have been offered and have read or had explained to me the COVID-19 Vaccine Screening Questions and Guidance.
- I also have been offered and have read or had explained to me the Fact Sheet for Patients and Parents/Caregivers for the Moderna COVID-19 Vaccine that I am receiving today.
- I understand the risks and benefits of receiving the Moderna COVID-19 Vaccine.
- I understand the Moderna COVID-19 Vaccine is FDA approved for people 18 years of age and older as a 2 dose series. For people 6 months to 17 years of age (primary series), the third primary dose for immunocompromised people, and the booster dose for people 6 months of age and older, the Moderna COVID-19 Vaccine is available under emergency use authorizations (EUA) and has not been fully approved by the FDA.
- I understand the potential risks, including serious allergic reactions (anaphylaxis). Other reported adverse reactions include injection site pain, swelling, or redness, fatigue, headache, muscle pain, chills, joint pain, fever, nausea, and swollen lymph nodes.
- I understand there may be other potential ways to prevent COVID-19.
- I was given the chance to ask questions and all questions were answered.
- I agree to receive the Moderna COVID-19 Vaccine.

☐ **I GIVE CONSENT** to The Facility and its staff to vaccinate me with the Moderna COVID-19 Vaccine (the COVID Vaccine). (If you choose this option but do not sign below, then you or the person named above for whom you are giving consent will not be vaccinated).

Signature of Recipient/Healthcare Proxy _____ Date: month___day___year____

If signing for someone other than yourself - Printed Name: _____ Relationship: _____

COMPLETE THIS SECTION ONLY IF CONSENT TO RECEIVE THE COVID-19 VACCINE IS GIVEN.

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine Manufacturer	Date Dose Administered	Lot Number	Dose	Name of Vaccine Administrator
Moderna (Primary Series)	/ /		☐ First Dose ☐ Second Dose ☐ Third Dose	
Moderna bivalent (Booster)	/ /		☐ Booster Dose	

Section 6: Definitions

- **Moderately or severely immunocompromised**
  Your provider is best able to assess your degree of immunocompromise and optimal timing of vaccination. Moderate or severe immune compromise may be caused by immunosuppressive or immunomodulatory therapies (for example, active cancer treatment, CART-T-cell therapy, high-dose steroids) or medical conditions that affect the immune system (for example, solid-organ transplant, stem cell transplant within last 2 years, moderate or severe primary immunodeficiency, advanced or untreated HIV infection).

Section 7: Notice of Privacy Practices

- I have been offered The Facility's Notice of Privacy Practices.
- By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of Recipient/Healthcare Proxy _____ Date: month___day___year____

Section 8: Consent to Bill/Assignment of Benefits

- I will not be personally responsible for any cost or fee associated with the COVID Vaccine.
- If I am a beneficiary under any insurance or health plan or government-sponsored program (Plan/Program), I understand that the Plan/Program may be billed for the administration of the COVID Vaccine.
- I assign to The Facility any benefits under my Plan/Program for the administration of the COVID Vaccine.
- I authorize The Facility to directly bill my Plan/Program for the administration of the COVID Vaccine.

- I instruct my Plan/Program to directly pay The Facility any benefits to which I am entitled for the administration of the COVID Vaccine.
- I authorize The Facility to keep any payment received from my Plan/Program for the administration of the COVID Vaccine.

Signature of Recipient/Healthcare Proxy _____ Date: month___day___year____