

Moderna COVID-19 Vaccine 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.

Section 2: Screening for Vaccine Eligibility	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had an intermediate or severe allergic reaction to any ingredient in the Moderna COVID-19 vaccine or to polysorbate? <i>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</i>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you below the minimum age requirement (18 years) for receiving the Moderna COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you received a previous COVID-19 vaccine made by a different manufacturer?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you received monoclonal antibodies or convalescent plasma to treat COVID-19 in the last 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	
6. 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. You may also receive a fourth (booster) dose 6 months after your third vaccine dose.	<input type="checkbox"/>	<input type="checkbox"/>	
7. If you have completed a primary vaccine series with the Moderna COVID-19 vaccine or Pfizer-BioNTech COVID-19 vaccine, do the below criteria apply to you? <ul style="list-style-type: none"> • 18 years of age or older • At least 6 months has elapsed since your second dose If yes, the Centers for Disease Control and Prevention (CDC) recommends a COVID-19 vaccine booster shot for you. Any of the currently available COVID-19 vaccines may be used for your booster dose (this consent form is for the Moderna COVID-19 vaccine).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If you have completed the single primary dose of the Janssen COVID-19 vaccine, do the below criteria apply to you? <ul style="list-style-type: none"> • 18 years of age or older • At least 2 months has elapsed since your dose If yes, the CDC recommends a COVID-19 vaccine booster shot for you. Any of the currently available COVID-19 vaccines may be used for your booster dose (this consent form is for the Moderna COVID-19 vaccine)..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For the first 5 questions, if 'no' or 'N/A' answers, progress to the next section. For 'yes' answers, please seek guidance.

Section 3: 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 went through a special process called an emergency use authorization (EUA), including for the third dose for certain immunocompromised people and the booster dose for certain people 18 years of age and older. The Moderna COVID-19 Vaccine has not been fully reviewed and 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 will not be vaccinated).

Signature of Recipient/Healthcare Proxy _____ Date: month ___ day ___ year ____

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

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine Manufacturer	Date Dose Administered	Lot Number	Dose	Name of Vaccine Administrator
Moderna	/ /		<input type="checkbox"/> First dose <input type="checkbox"/> Second dose <input type="checkbox"/> Third dose <input type="checkbox"/> Booster dose	

Section 5: 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 6: 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 7: 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 ____