VERIFIED ID _____ Moderna Primary Series NEXT APPT _____

# Moderna COVID-19 Vaccine Consent

Cedar County Public Health
400 Cedar St. Tipton, IA

## PATIENT INFORMATION

| LAST NAME: | FIRST NAME: | MIDDLE INITIAL: | GENDER (circle one): Male Female Other |
|---|---|---|---|
| | | | |

| DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___ | AGE: | PHONE NUMBER: |
|---|---|---|
| | | |

| STREET ADDRESS: | CITY: | STATE: | ZIP CODE: |
|---|---|---|---|
| | | | |

**Any Known Allergies (Please list):**

| PLEASE ANSWER ALL QUESTIONS | CIRCLE ONE | |
|---|---|---|
| 1. Have you previously received a dose of COVID-19 vaccine? If yes, was it Pfizer, Moderna, or Johnson & Johnson? | YES | NO |
| 2. Are you sick today? (For example: a cold, fever, or acute illness) | YES | NO |
| 3. In the past 14 days have you been diagnosed with COVID-19 or been in close contact with someone with COVID-19? | YES | NO |
| 4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | YES | NO |
| 5. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.?) | YES | NO |
| 6. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital? | YES | NO |
| 7. Do you have a bleeding disorder or are you taking a blood thinner? | YES | NO |
| 8. Does your provider consider you immunocompromised, or do you take medication that effects your immune system? | YES | NO |
| 10.. **Dose Number 2 Only, Have there been any changes to your responses to the questions listed above? OR did you experience a severe reaction following a previous dose of COVID-19 vaccine—including myocardi-** | YES | NO |

## CONSENT FOR VACCINATION

- The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine is approved by the FDA for the prevention of COVID-19 in persons 18 years of age and older.
- I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- I certify that the information I provided for payment and consent is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, Blue Cross Blue Shield, or other insurance to make payments directly to Cedar County Public Health.

**Patient Signature: X** _____ **Date:** _____

## INSURANCE

| INSURANCE COMPANY NAME: | UNINSURED ◯ |
|---|---|
| IDENTIFICATION NUMBER: | |
| NAME OF CARD HOLDER: | BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___ |

## FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications — LOT #:

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

| DOSE 1- IRIS | DOSE 1- NN | DOSE 1-BILLED |
|---|---|---|
| | | |

## FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications — LOT #:

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

| DOSE 2- IRIS | DOSE 2- NN | DOSE 2-BILLED |
|---|---|---|
| | | |