MODERNA

MEDICAL ARTS HOSPITAL

MODERNA COVID-19 VACCINE is a vaccine developed by Moderna to prevent disease caused by COVID-19. This vaccine has been authorized by the US Food & Drug Administration (FDA) for use under an Emergency Use Authorization (EUA). There is no FDA approved vaccine to prevent COVID-19. The purpose of this form is to obtain your consent to receive this vaccine.

Exclusion Questions: Answering yes to either of these questions excludes you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g., anaphylaxis) to any component of the Moderna COVID-19 Vaccine: SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.	Yes	No
Are you younger than 18 years of age?	Yes	No

Screening Questions: *Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their provider prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy (i.e. convalescent plasma or a monoclonal antibody) as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?*	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No

Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No
If yes to any of the above, I attest that I have discussed my condition with my provider and vaccination is recommended or I acknowledge that there may be risks and consent to proceed with vaccination	Yes	No

* Pregnant women and breastfeeding women have not been included in any COVID vaccine clinical trials to date, so there is currently no safety data specific for this population. If you are pregnant, plan to become pregnant, or are breastfeeding, we strongly recommend you speak to your care provider before getting the vaccine.

Caregiver safety is our number one priority. By receiving this COVID-19 vaccine you are agreeing to our safety protocol, which requires caregivers remain in the vaccination area for at

Acknowledgement and Consent to Receive Vaccination

The following has been discussed with me or I have been provided information about:

- The FDA has authorized the emergency use of Moderna COVID-19 Vaccine, which is not FDA approved in this population, for vaccination against COVID-19.
- The option to accept or refuse vaccination and alternative options.
- Information on available alternative vaccines and the risks and benefits of those alternatives.
- Significant and potential risks and benefits of vaccination, and the extent to which they may occur, is not known at this time.

I have been provided a copy and/or opportunity to review the EUA Fact Sheet

- FDA Fact Sheet for Patients/Patients/Caregivers
- I have been provided a vaccination card with the timeframe for when I need to return for the second dose of Moderna COVID-19 Vaccine.

I understand and agree that this consent form and records relating to my vaccination will be maintained in designated records, including, if applicable, my medical record and/or my occupational health record.

I consent to the release of my information to state or federal health authorities (e.g. state immunization registries) for the purpose of tracking immunizations during the public health emergency.

I was provided information on the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine.

I acknowledge and agree that I understand the nature of receiving the Moderna Covid-19 Vaccine, including the risks and benefits known at this time and the available alternatives. I have received the information discussed above and had my questions answered to my satisfaction.

My consent to receive the Moderna Covid-19 Vaccine under the EUA will continue until I have completed the vaccination schedule of two doses, I experience a significant adverse reaction to the vaccine, or my goals of care have changed. I understand that I am free to withdraw consent and stop treatment prior to the second dose. I understand that stopping the vaccination series will not impact other medical care and treatment options.

MANUFACTURER	LOT NUMBER	EXP DATE	DOSE	IM SITE
Moderna			0.5 ml	L-Deltoid R-Deltoid

Recipient printed name: _____ EID or NPI: _____
First M.I. Last

Recipient address**: _____ State: _____ Zip: _____

Recipient date of birth**: _____ Recipient Phone Number: _____

Recipient signature: _____ Date: _____

Clinician signature: _____ Date: _____

**for required state immunization registry reporting