Providence

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 any 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
Immediate allergic reaction of ANY severity to a previous dose of an mRNA COVID-19 vaccine or any of its components, including polyethylene glycol (PEG) or polysorbate (due to potential cross-reactive hypersensitivity with PEG)?	Yes	No
Are you younger than 18 years of age?	Yes	No
Have you received any vaccination(s) of any kind in the last 14 days? Answering "Yes" to this question excludes you from receiving the vaccine at this time.	Yes	No

Screening Questions: *Vaccinator: If patient answers "yes" to any of the below, consult with provider prior to proceeding with administration.*

Are you feeling sick today?	Yes	No
Have you ever received a dose of COVID-19 vaccine?	Yes	No
• **If yes, which vaccine product did you receive?** **☐Pfizer ☐Moderna ☐Another product_____**		
In the past two weeks have you tested positive for COVID-19?	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 weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	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: _____ ***Note: must remain in observation area for 30 minutes post vaccination***	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	N/A

** 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.*

**Vaccinator if patient answers yes to question concerning blood thinner, instruct patient to monitor injection site for bruising and swelling. If develops, patient may use compression and ice to relieve symptoms.*

I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body, or dizziness and weakness, I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.

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 (https://www.fda.gov/media/144638/download)

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

I was provided information on the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html)

I confirm that I have been told about the pros and cons of this vaccine and have been able to ask any questions. I consent to receive this vaccine injection.

MANUFACTURER	LOT NUMBER	EXP DATE	VACCINE #	DOSE	IM SITE
Moderna			1st Dose 2nd Dose	0.5 ml	L-Deltoid R-Deltoid

Date of Vaccine:_____ Time of Vaccine:_____ Vaccine Conservation Dose: ☐

EUA Date:_____

Recipient printed name: _____

Recipient address**: _____

City: _____ State: _____ Zip: _____

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

Recipient signature: _____ Date: _____

Vaccinator signature: _____ Date: _____

**for required state immunization registry reporting

Licensed verification by:_____ (Print Name and credential)