

Wood County Health Department COVID-19 Vaccine Registration and Consent for MODERNA Vaccine

First Name:	Middle:	Last:
Date of Birth:	Age:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Unknown
The recipient must be at least 18 years old to receive this vaccine.		
Do you consider yourself Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Prefer not to say		
Which category or categories best describe your race?	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Prefer not to say	
Street address:		
City, State and Zip:		
Phone Number:	Email Address:	
If an emergency happens today, who should we contact?		
Name:	Phone number:	
List names and dates of all previous COVID vaccines:		
1 st dose: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Johnson & Johnson	Date:	2 nd dose: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> N/A

Please select the primary reason you are receiving the COVID-19 vaccine. (Please check only one box.)

Age: 18-39 40-49 50-59 60-64 65-69 70-74 75-79 80 or older

Place of Residence or Occupation

- Assisted Living Facility – Resident or Staff
 Childcare Services Worker
 Congregate Care Facility – Resident or Staff
 Emergency Medical Services (EMTs/Paramedics)
 Funeral Services Worker
 Healthcare Worker
 Hospital – Clinical , Administrative or Ancillary Staff
 Non-Hospital – Clinical , Administrative or Ancillary Staff
 Law Enforcement, Corrections, Firefighter
 School (K-12) Staff
 Skilled Nursing Facility (RCF) – Resident or Staff
 State of Ohio
 Dept. of Dev. Disabilities (DODD) – Resident or Staff
 Dept. of Rehabilitation & Correction LTC – Resident or Staff
 Mental Health and Addiction Services (MHAS) – Resident or Staff
 Veterans Home – Resident or Staff

Health Condition

- ALS (amyotrophic lateral sclerosis)
 Bone marrow transplant recipients
 Cancer
 Chronic kidney disease
 Chronic obstructive pulmonary disease (COPD)
 Congenital or early onset conditions with intellectual or developmental disabilities
 Congenital or early in life conditions that carried into adulthood without intellectual or developmental disabilities
 Diabetes type1 or type 2
 End stage renal disease
 Heart disease
 Obesity
 Pregnant

Screening Questions

Are you sick today? (fever, congestion, cough)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you ever had a severe allergic reaction that required epi (epinephrine)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you ever had any allergic reaction to a vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Have you been treated for COVID-19 in the last 90 days with passive antibody therapy (monoclonal antibodies or convalescent serum)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you have a weakened immune system caused by something such as HIV or cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you take medications or other therapies that suppress your immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Females: Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No

Turn Over. >>>

Name: _____

Date of Birth: _____

Informed Consent to Vaccinate

Initial each line.

By initialing and signing below you agree that you are authorized to consent to the vaccination of the patient.

___ I am seeking the **Moderna** vaccine today for:

___ A first or second dose of the original vaccine series (I agree to timely receive both the first and the second dose.)

___ A third dose for individuals who are determined to have certain kinds of immunocompromise

___ A booster dose

___ I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of the injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, swollen lymph nodes or generally feeling unwell.

___ I understand that the vaccine may cause a severe allergic reaction which may include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness).

___ I understand that myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received the vaccine.

___ I understand that the above listed side effects may not be all the side effects of the COVID-19 vaccine.

___ I understand that the vaccine is still being studied in clinical trials.

___ I understand that all possible side effects or complications associated with the vaccine cannot be predicted.

___ I understand that any long-term side effects or future complications from this vaccine are unknown at this time.

___ I acknowledge that I have been given a copy, have viewed or had explained to me the Emergency Use Authorization Fact Sheet about the vaccine to be administered to me and information about the disease.

___ I acknowledge I had the opportunity to ask questions and understand both the presently known benefits and the risks of this vaccine.

___ I acknowledge I had an opportunity to decline having this vaccine administered to me.

___ I acknowledge and understand that unless I request otherwise, a record of my vaccination shall be provided to a state-wide Immunization Registry for the purpose of immunization tracking, recall and recording.

___ I confirm that the person being vaccinated is 18 years of age or older at the time of vaccination.

___ I confirm that the person being vaccinated has not received a COVID vaccine from another manufacturer that would make receipt of a **Moderna** COVID-19 vaccine today inconsistent with CDC guidance.

___ I certify that I am (a) at least 18 years of age or (b) acting at the request of the patient.

___ I hereby give my consent to the administration of a **Moderna** COVID-19 vaccine.

Print name of person giving consent to vaccinate. DOB: / /	Patient consent/signature (or parent/guardian)	Date of consent
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Turn this form in before you leave the event.

Vaccination and Records Staff Use Only

Manufacturer: <input type="checkbox"/> Moderna	Anatomical Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
Lot Number:	Date of vaccine: <input type="checkbox"/> 1 st Dose <input type="checkbox"/> 2 nd Dose <input type="checkbox"/> 3 rd Dose
Expiration Date:	Vaccinator's Name: