COVID-19
Coronavirus

***ARE YOU ALLERGIC TO LATEX? TELL NURSE IF YOU ARE! ***

NAME: _____ ____ _____ **SEX:** M F
FIRST MI LAST

DATE OF BIRTH: ____/____/____ ____ **PRIMARY PHONE #:**____-____-____
Month Day Year **Age**

STREET ADDRESS **CITY** **STATE** **ZIP CODE**

- I have read or have had explained to me the information in the Fact Sheet about the Emergency Use Authorization of the **Moderna Covid-19 vaccine**. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the Covid-19 vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the Covid-19 vaccine given to me (or the person named above). I have completed the pre-vaccination form. The person receiving this vaccine is in good health at this time and is not allergic to latex I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of bleeding disorder or on a blood thinner or have ever had a serious allergic reaction or other problems after getting any vaccination.
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE) and JCHD's electronic billing system.
- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders.
- I will not hold the Jefferson County Health Department or any Orthopaedic Center of Southern Illinois healthcare practitioner giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I have been provided with Notice of Privacy Practices.

SIGNATURE:_____ **DATE:**_____

Pre-Vaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____