Family Care Associates of Effingham

COVID-19 Moderna Vaccine Consent Form

Section 1: Patient Information (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **month_____ day_____ year _____ Age ____**
ADDRESS			**DAYTIME PHONE NUMBER:**
CITY	**STATE**	**ZIP**	**PHYSICIAN:**

	YES	NO
1. Are you feeling sick today? (e.g., cold, fever, acute illness?) *Defer vaccination until after illness*		
2. Do you have allergies to any medications, eggs, gelatin, neomycin, baker's yeast latex or any other vaccines?		
3. **Have you experienced a severe allergic reaction to any vaccine or an injectable medication in the past? **If yes, you will need to stay 30 minutes for observation after vaccination**.		
4. In the past two weeks, have you received any vaccinations or TB skin test?		
5. I am pregnant, plan to become pregnant in the next 2 months or breastfeeding, and I have been counseled by my Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine. **Script from physician must be provided for these clients**.		N/A
6. I have had COVID in the past 90 days. (Moderna COVID-19 Vaccine should be deferred for at least 90 days)		
7. Have you received a COVID-19 vaccine? If yes, what brand of COVID-19 vaccine have you been vaccinated for?		
8. Do you have a bleeding disorder or are you on a blood thinner?		
9. Are you immunocompromised or are you on a medicine that affects your immune system?		

Section 2: Consent

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

The **COVID 19 vaccine is a series of two (2) injections, spaced apart based on manufacture and FDA guidelines. Please ensure that you can complete the series before consenting to this vaccine administration.**

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential in adults, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

I consent to the administration of two injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the attached Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the vaccine is a series of two injections and I intend to complete the series vaccination. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

- The Moderna COVID-19 Vaccine Emergency Usage Authorization fact sheet can be found using the QR code: or by visiting our website at: www.familycareassociates.com.
- 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).
- I understand that you may bill my insurance or other funding source for an administration fee; but there will be no cost to me.

Signature: _____ **Date: (month ____ day ____ year 2021)**

Race _____ **Ethnic Group: Hispanic/Latino Not Hispanic/Latino**

Section 3: Permission to Release Information

My signature above gives Family Care Associates of Effingham permission to release information regarding my vaccinations to my physician. I have been given the opportunity to read the Notice of Privacy Practices and given a copy if requested.

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Vaccine Manufacturer	Lot Number Exp Date	Name and Title of Vaccinator
COVID-19	/ /	**IM**	**R deltoid** **L deltoid**	**Moderna**		