COVID-19 Vaccine Screening and Agreement

Information collected on this form will be used to document that you have received vaccine(s). Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you have questions about MIIC, refer to MIIC and the Public (www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

Contact information – person being vaccinated

Patient's name (last, first, middle): _____

Date of birth: _____

Age: _____

Primary phone number: _____

Address (street or P.O. Box): _____

City: _____

State: _____

Zip code: _____

Agreement

I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: **Moderna.** I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.

Signature of patient or parent/guardian: _____

Date: _____ / _____ / _____

Health history

Talk to your health care provider prior to vaccination if you answer yes to any of the following:

Yes	No	Unknown	Question
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) to a previous dose of COVID-19 vaccine? If yes, please specify:
Yes	No	Unknown	History of severe allergic reaction (e.g., anaphylaxis) to a component of the COVID-19 vaccine?
Yes	No	Unknown	History of severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular (in the muscle), intravenous (in the vein), or subcutaneous (under the skin))?
Yes	No	Unknown	Currently ill due to COVID-19 or other illness?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	In the last 14 days exposed to another person with known COVID-19 disease?
Yes	No	Unknown	Have you ever received a dose of COVID-19 vaccine? If yes, list vaccine product:
Yes	No	Unknown	Are you currently pregnant or breastfeeding?
Yes	No	Unknown	In the last 14 days, have you received another vaccination for any reason? (e.g. the flu shot)

DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation[1]	EUA Fact Sheet Date	Route[2]	Manufacturer[3]	Lot Number	Admin Site[4]	Person Admin[5]
COVID-19 (Moderna)		IM	MOD			

1. **COVID-19 Vaccine Presentation** = list specific product name (i.e. Pfizer, Moderna, etc.)
2. **Route:** IM = Intramuscular
3. **Manufacturer:** MOD = Moderna
4. **Site Vaccine Given:** LD = Left Deltoid, RD = Right Deltoid, LT = Left Thigh, RT = Right Thigh
5. **Signature or initials of person administering vaccine:** Can be used if more than one person is administering vaccines

Signature and title of person administering vaccine: _____

Date administered: ___/___/_____