COVID VACCINE ADMINISTRATION CONSENT FORM

Medical Arts Associates - 1632 116th Avenue NE, Suite C, Bellevue, WA 98004

LAST NAME	FIRST NAME	MIDDLE NAME	BIRTHDATE

ADDRESS	CITY	STATE	ZIP

		Cell: Home:
AGE	SEX	PRIMARY PHONE

VACCINE RECIPIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

The following questions will help us determine if there is any reason you should not receive the COVID-19 vaccine. If you answer **yes** to any of the questions it does not necessarily mean you will not be vaccinated. Additional questions may be asked and if a questions or response if not clear, please refer to your healthcare provider for more information.

	Question	Yes	No
1.	Are you feeling sick today?		
2.	Have you ever received a dose of COVID-19 vaccine?		
3.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something?		
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 been told by a doctor you that you had COVID-19?		
7.	Do you have a weakened immune system or take immunosuppressive drugs or therapies?		
8.	Do you have a bleeding disorder or taking a blood thinner?		
9.	Are you pregnant or breastfeeding?		
10.	Do you have dermal fillers?		

HIPAA Compliance Patient Consent Form **Please Initial:_____**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your initials that you have reviewed our notice before signing this consent.

I have received the Vaccine Fact Sheet for the immunization which I am requesting and have read or have had the information explained to me. I have had the opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request that it be given to me or to the person named above for whom I am authorized to make this request.

Patient Signature:	**Date:**

OFFICE USE ONLY	
Vaccine	COVID-19
Manufacturer	Moderna
Lot#	017C21A
Dose	0.5mL
Route	Intramusclar
Site	Left or Right (circle one)
Signature of Vaccine Administrator:	**Date:**

FACT POINTS FOR COVID 19 VACCINE RECIPIENTS

The following points are important to note as you consider receiving the Moderna COVID 19 vaccine. You are being provided with a detailed factsheet about this vaccine to make an informed decision to **RECEIVE** or **NOT RECEIVE** the immunization. Place take the time needed to review all documents.

- The Moderna Vaccine is administered as a 2-dose series, 1 month apart and may not protect everyone.
- This is an unapproved vaccine that may prevent COVID 19. There are no approved vaccines at this time, but the Moderna vaccine does have an Emergency Use Authorization at this time from the FDA, which allows for its use in persons 18 years and older.
- You should not get the vaccine if you have had a severe allergic reaction to a previous dose of the Moderna Vaccine or you have an allergic reaction to one of the ingredients. The ingredient list can be found on page 2 of the detailed information.
- Pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness) and redness as well as general side effects like fatigue, headache, muscle pain, joint pain, chills nausea, and vomiting and fever
- There is a remote chance the vaccine could cause severe allergic reactions. This usually occurs between a few minutes and an hour after getting the vaccine. Signs of a severe allergic reaction include: difficulty breathing, swelling of the face and throat, a fast heartbeat, a bad rash all over your body and or dizziness and weakness. Other side effects may occur. We will have you wait for 15 minutes after your vaccination with medical help nearby.
- If you experience a severe allergic reaction after you leave, call 9-1-1 or go to the nearest hospital.
- The decision to take this vaccine is your choice.
- If you are pregnant or breastfeeding, discuss with your healthcare provider before getting the vaccine.
- You will be issued a card as proof of your vaccination, and when to expect the follow-up vaccination.

Your signature on this document indicates your understanding of the risks and that you voluntarily assume all responsibility for any reactions that may result from the receipt of the immunization.

Patient Signature:	**Date:**

The following question relate to VOLUNTARY information requested from the federal government as part of funding for federally qualified health centers.

What is your ethnicity/race? Please indicate by marking the appropriate box below:	
	White
	Black or African American
	Hispanic or Latino
	Asian American
	American Indian or Alaska Native
	Native Hawaiian or Other Pacific Islander
	Filipino - American
	Two or More Races (not Hispanic or Latino)–All persons who identify with more than one of the above races.