PHOENIX ER
& MEDICAL HOSPITAL

Temp:_____

IMMUNIZATION SCREENING & CONSENT FORM

PLEASE PRINT

First Name:_____ **Last Name:** _____

Street Address: _____ **City:** _____ **Zip Code:** _____

Male ◯ **Female** ◯ **Date of Birth:** _____ **Age:** _____ **Phone Number:** _____

Race: ◯ White ◯ Black or African American ◯ Hispanic ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander ◯ Other

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino **Insured for vaccines?** No ◯ Yes ◯

Name of Insurance: _____ **Group:** _____ **ID/SS#**_____

Screening Questions:

The following questions will help us determine if there is any reason, we should not give you the Moderna 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 must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today? ◯ Yes ◯ No
2. Have you tested positive for COVID-19 in the last 14 days? ◯ Yes ◯ No
3. Have you had any Monoclonal antibody treatment for COVID-19 in the last 90 days? ◯ Yes ◯ No
4. Have you had any vaccines in the last 14 days? ◯ Yes ◯ No
5. Is this your first dose of the COVID Vaccine? ◯ Yes ◯ No
   If no, what manufacture was your first dose and when did you get it?
   Date:_____ ◯ Moderna ◯ Pfizer ◯ Other/Unknown
6. Do you have a history of <u>severe allergic reaction</u> to any component of the vaccine, specifically Polyethylene glycol or PEG?
   ◯ Yes ◯ No If yes, please consult with your physician prior to receiving this vaccine.
7. Do you have a history of <u>severe allergic</u> reaction to another vaccine or injectable medication?
   ◯ Yes ◯ No If yes, we will observe you for 30 minutes after vaccination.
8. Are you a patient with an immunocompromised condition, are pregnant, or breastfeeding and had the opportunity to discuss the decision to vaccinate with your healthcare provider and/or are you ready to proceed with vaccination?
   ◯ Yes, I have discussed with my physician and would like to be vaccinated.
   ◯ No, I do not have any conditions that would require a discussion with my physician prior to vaccination.

☐ **I have been given a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID 19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER.**

Patient signature:_____ Name _____ Date_____

Staff Only: Vaccine Administration: Moderna Covid-19 vaccine ☐ Site:_____
Signature_____ Date_____ Time:_____
Vaccine label or lot number_____ Expiration Date_____ NDC number_____