INTERMOUNTAIN IMMC MEDICAL CLINIC Our specialty is you

Moderna COVID-19 Vaccine Patient Acknowledgment and Consent

Patient Name (Last, First): _____ DOB:_____/_____/_____

Cell Phone: _____ Email:_____
(This information will be used to contact you for your second dose reminder, please circle reminder preference contact method.)

Primary Care Provider: _____

Address: _____

City, State, Zip Code: _____

Vaccine Dose (check one): □ 1st □ 2nd If this is your second dose, what vaccine was your first?
□ Pfizer □ Moderna □ Don't know.
If this is your second dose, when did you receive your first dose? (date): _____.

Exclusion Questions: *Answering "yes" to ANY of the following questions below will exclude you from receiving the vaccine*.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.	Yes	No
Are you under the age of 18 years?	Yes	No
Have you received another vaccine within the last 14 days (if you answer yes, you must wait at least 14 days before receiving this vaccine)	Yes	No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?	Yes	No

Screening Questions: *Answering "yes" to ANY of the following, you'll be scheduled to consult with your provider prior to receiving the vaccine.*

Are you feeling ill today?	Yes	No
Have you ever had Guillain Barre in conjunction with a previous vaccination?	Yes	No
Is it possible that you are or may become pregnant in the next four weeks, or are currently breastfeeding?	Yes	No
Are you currently taking an immunosuppressant medication (e.g. Prednisone)?	Yes	No
Have you ever had an anaphylactic reaction (e.g., trouble breathing, broke out in hives, had facial or tongue swelling, had low blood pressure), or had other severe symptoms after receiving another vaccination or an injectable medication (a shot given intravenously, intramuscularly, or subcutaneously)?	Yes	No
Do you have a history of anaphylactic reaction to anything other than a vaccine or injectable medication (food, insect sting, oral medication)	Yes	No

Acknowledgements and Consent for Vaccination:

- *I understand that the vaccine clinic is being held in a group setting but I may request individual counseling in a private room if I wish by notifying an InterMountain Medical Clinic staff member.*

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the Fact Sheet for Vaccine Recipients and Caregivers* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*

- *I have had the opportunity to ask questions about this vaccination. I believe I understand this information, and my questions have been answered to my satisfaction.*

- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. There is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*

- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization, so I am near my health care provider if I have any adverse reactions. I must stay for 15 minutes.*

- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 911 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*

- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*

- *I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time from InterMountain Medical Clinic. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. If I do not get the second dose, the chance that I will become immune may go down.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.*

Patient (or Parent/Guardian/Authorized Representative) Signature:

_____

Date: _____

Name of Parent, Guardian or Authorized Representative:

_____

Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.