



MODERNA COVID-19 VACCINE CONSENT

Name: _____ DOB: _____

Address: _____

Phone: _____

1. Are you feeling sick today? ____Yes ____No

2. Have you ever received a dose of COVID-19 vaccine? ____Yes ____No
If yes, which product?
 Pfizer Moderna another product _____

3. Have you ever had a severe allergic reaction to COVID-19 vaccine? ____Yes ____No

4. Have you recently tested positive for COVID-19? ____Yes ____No
• If yes, when? _____

5. Have you received passive antibody therapy as treatment for COVID-19? ____Yes ____No

The following questions will help us determine if there is any reason you should not get the 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 may be asked. If a question is not clear, please ask your healthcare provider. I have read and understand the fact sheet by the FDA and that BCMH is required to submit data to MCIR and report adverse events to Vaccine Adverse Event Reporting System. I understand and agree to all of the above and give my consent to bill my insurance for the administration of the vaccine.

Patient/Guardian Signature: _____ Date: _____

*****FOR CLINIC USE ONLY*****

Moderna: 1st Dose 2nd Dose Lot # 017B22A Expiration Date: 11/22/2022

Moderna Bivalent: Booster Lot # 303G22B Expiration Date: 07/31/2023

0.5 mL given IM: Right Deltoid Left Deltoid

Administered by: _____ Date: _____ Entered into MCIR: _____

This Box Clinic Use Only:

Place Insurance Card in This Box Once
Document is Complete and Take Photo

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