CAMARENA HEALTH

We are community. We are family. We are health.

COVID-19 Vaccination Consent Form

Patient Information:

Last Name:	First Name:
DOB:	Phone:

Health Assessment and Questionnaire:

Please answer the following questions by circling your response:		
Are you feeling sick today?	YES	NO
Have you ever received a dose of COVID-19 Vaccine	YES	NO
- If yes, which product	Pfizer	Moderna
Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	YES	NO
- Was the severe allergic reaction after receiving a COVID-19 vaccine?	YES	NO
- Was the severe allergic reaction after receiving another vaccine or another injectable medication?	YES	NO
Are you allergic to any of the Moderna COVID-19 Vaccine components/ingredients? *See the Moderna COVID-19 Vaccine Fact Sheet*	YES	NO
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
Have you received another vaccine in the last 14 days?	YES	NO
Have you had a positive test for COVID-19 or has a medical provider ever told you that you have had COVID-19?	YES	NO
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	YES	NO
Do you have a bleeding disorder or are you taking blood thinners?	YES	NO
Are you pregnant, think you may be pregnant or breastfeeding?	YES	NO

Acknowledgement and Consent for Vaccination

I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) regarding the Moderna COVID-19 Vaccine. I understand the expected benefits and possible risk ad side effects of the vaccine. I have had all my questions answered. I hereby give my permission for the agent of Camarena Health to administer the Moderna COVID-19 Vaccine in accordance to the recommendations of the Centers for Disease Control (CDC).

_____ _____

Patient Signature Date

Vaccination Administration- Intramuscular Injection in the Deltoid

Moderna COVID-19 Dose #____	Date:	☐ Left Deltoid	☐ Right Deltoid	Staff Name & Initials

CAMARENA HEALTH
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