Snoqualmie Valley HEALTH

Moderna COVID-19 Vaccine
Patient Acknowledgment

Participant Last Name: _____ First Name: _____

DOB: ____/____/_____

Phone: _____ Mobile Phone: _____Email: _____

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):
Male: ☐ Female: ☐

Gender identity (check one):
Male: ☐ Female: ☐ Non-Binary ☐ Unspecified/Indeterminant: ☐

Ethnicity (Check one):
Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐ Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ Asian ☐ Hawaiian or Pacific Islander ☐ White ☐ American Indian or Alaska Native ☐

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine freely and on my own. 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 know the Food and Drug Administration (FDA) has authorized the emergency use of Moderna, vaccines. I know they are not fully licensed FDA vaccines. 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. If I have a history of certain allergic reaction(s), I must stay for 30 minutes. If I do not have a history of such an allergic reaction(s), 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 9-1-1 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 receive the recommended number of doses of each COVID-19 vaccine to complete the primary series, and I must receive the same vaccine each time. 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 to complete the primary series of the vaccine, but if I do not complete the primary series there will be less chance that I will become immune*

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. If I am an employee of Snoqualmie Valley Hospital I understand that it will keep records of this vaccination for me in their electronic occupational health records.*

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.

Signature or Participant (or Guardian/Authorized Representative: _____

Today's Date of Immunization: _____

Snoqualmie Valley HEALTH

Moderna Vaccine
Pre-Immunization Screening Questions

(For completion on day of immunization)

Participant Last Name: _____ First Name: _____

DOB: ____/____/_____

Exclusion Questions: Answering yes to any of these questions excludes you from receiving the vaccine today

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to either the Moderna vaccine or any components of the vaccines? (Full list is available in the Fact Sheet for Vaccine Recipients and Caregivers or from your health care provider.)	Yes	No
Are you younger than 6 months old for Moderna?	Yes	No
In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you been exposed to a person who has tested positive for COVID-19?	Yes	No
Within the past 10 days, have you had a new onset of fever, chills, runny nose, congestion, sore throat, cough, shortness of breath, fatigue, body aches, headache, loss of taste or smell, nausea, vomiting or diarrhea?	Yes	No
Do you have a history of pericarditis or myocarditis?	Yes	No
Do you have a known history of anaphylaxis or immediate allergic reaction from any cause? Do you experience lightheadedness or dizziness after vaccines or injections?	Yes	No

Additional Questions Prompts:

In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment? –or- Are you immune compromised or on a medicine that affects your immune system?	Yes *Your immune response to the vaccine may be less*	No
Are you pregnant, breastfeeding, or do you plan to become pregnant?	Yes *Few pregnant or breast-feeding women were in trials*	No
Do you have a bleeding disorder or are you on a blood thinner (other than aspirin)?	Yes *You may get a knot in the muscle from the injection*	No

Signature or Participant (or Guardian/Authorized Representative: _____

Today's Date of Immunization: _____

Administrative use only during system down-time or off-site:

Administration date:_____ Administration Time: _____ CVX (Product): _____ Dose number: _____Lot number: _____	Vaccine administering provider suffix: _____ Vaccine administering site on body: Left deltoid ☐ Right deltoid ☐ Other (indicate location): _____ Vaccine route of administration: _____

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