LEGACY MEDICAL CARE
CONSENT FORM AND ADMINISTRATION RECORD
MODERNA SARS-CoV-2 Vaccine (COVID-19) 2020-2021

CLEARLY PRINT information below about the person receiving the vaccine.

Last Name: _____ **Middle Initial:** ___ **First Name:** _____
Date of Birth: _____
Sex: ☐ Male ☐ Female ☐ Other **Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Choose not to disclose

Race: ☐ American Indian/ Alaskan Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic/Latino
☐ Native Hawaiian/ Other Pacific Islander ☐ Other Race/Multiracial ☐ Prefer not to disclose.
Home Address: _____ **City:** _____ **State:** ___ **Zip:** _____
County: _____ **Phone Number** _____
Please answer all the questions below.

1. Are you currently in quarantine or isolation? ..... ☐ YES ☐NO
2. Have you had passive antibody therapy for COVID-19 in the last 90 days?..... ☐ YES ☐NO
3. Are you experiencing moderate or severe acute illness with or without fever including any COVID symptoms?..... ☐ YES ☐NO

If you answered YES to any of the questions above this clinic is not able to provide the vaccine at this time.

4. Are you over 18 years of age? ..... ☐ YES ☐NO
5. Have you received a vaccine in the last 14 days? ..... ☐ YES ☐NO
   If yes, which one(s)? _____
6. Have you ever received a COVID-19 Vaccine? ..... ☐ YES ☐NO
   If yes, when and what brand? _____
7. Have you tested positive for COVID? ..... ☐ YES ☐NO
   If yes, when? _____
8. Do you have a bleeding disorder or are you taking anticoagulants (Aspirin/Warfarin/ Coumadin)? ..... ☐ YES ☐NO
9. Have you ever had a serious reaction to a vaccine (e.g., anaphylaxis)?..... ☐ YES ☐NO
10. Have you ever had a serious reaction to an injectable medication (e.g., anaphylaxis)?..... ☐ YES ☐NO
11. Are you allergic to any of the ingredients in the COVID vaccine?..... ☐ YES ☐NO

CONSENT

I have been given and read the Emergency Use Authorization (EUA) for the Moderna Vaccine and have had my questions answered about COVID-19 vaccine. I understand the benefits and the risks of the COVID-19 vaccine and ask that the vaccine be given to me. Moderna requires 2 doses, 28 days or more apart, to be fully effective. I agree to obtain the second dose. I consent to the administration of the vaccine by representatives of Legacy Medical Care (LMC). I fully release and discharge LMC, its affiliates and their officers, directors, employees, and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or my receipt of, the vaccine. I authorize the release of my information to be shared with the state or federal registry.

Signature: _____ **Date:** _____

FOR ADMINISTRATIVE USE ONLY

Administration Date	**Vaccine Manufacturer Moderna COVID-19 Lot #**	***Vaccine Administrator*** ***Signature*** ***Title***	**Route I M** *(Circle)*	**Dose Administered**
			R deltoid L deltoid	0.5 mL

☐ New Patient ☐ Established Patient Insured: ☐ YES ☐ NO

Information entered in I-CARE: Initials: _____ Date_____/_____/_____