Moderna/Spikevax COVID-19 (2023-2024 Formula) **LEGACY MEDICAL CARE**
SARS-CoV-2 Vaccine (COVID-19), Moderna/Spikevax (2023-2024 Formula)
CONSENT FORM AND ADMINISTRATION RECORD

CLEARLY PRINT information below about the person receiving the vaccine.

Last Name: _____ **First Name:** _____ **Middle 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 under 6 months of age?	☐ YES	☐NO
2.	Are you currently in quarantine or isolation?	☐ YES	☐NO
3.	Have you received the Monkeypox vaccine in the last 4 weeks?	☐ YES	☐NO
4.	Have a history of COVID-19 positive within the past 3 months?	☐ YES	☐NO
5.	Are you experiencing moderate or severe acute illness with or without fever, including any COVID-19 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.

6.	Have you received MMR/Varicella/Proquad vaccines in the past 30 days?	☐ YES	☐NO
7.	Have you ever received a COVID-19 vaccine?	☐ YES	☐NO
	If yes, when and what brand? _____		
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/injectable medication (e.g., anaphylaxis)?	☐ YES	☐NO
10.	Are you allergic to any of the ingredients in the COVID-19 vaccine?	☐ YES	☐NO

NOTE: Please continue to protect yourself and others from COVID-19 with good hand washing, wearing a mask, maintaining social distance of at least 6 feet from others, and staying home when you are ill.

CONSENT: *I have been given and read the Emergency Use Authorization (EUA) or Vaccine Information Sheet (VIS) for the Moderna/Spikevax COVID-19 (2023-2024 Formula), and I 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/Spikevax COVID-19 (2023-2024 Formula) may require a series of doses to be considered fully vaccinated. I agree to obtain the series as recommended by the Illinois Department of Public Health IDPH.*
I consent to the administration of the vaccine by representatives of Legacy Medical Care (LMC). I fully release and discharge Legacy Medical Care, 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 attest I am eligible for the vaccine I am requesting per the Illinois Department of Public Health IDPH guidelines.
If you are under 18 years old, your custodial parent or a legal guardian may consent on your behalf and sign this form; minors may not consent for vaccination unless they are emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the Illinois Consent by Minors Act. If I am signing this document on behalf of a minor, I affirm that I have legal authority to consent to the minor's medical care.
I confirm that I am eligible for the vaccine I am requesting according to the Illinois Department of Public Health IDPH guidelines.

SIGNATURE: _____ *Relationship to minor:* _____ *Date:* _____

(If a minor, a parent or legal guardian must sign)

First and Last name of an additional individual who is authorized to bring the minor to receive the COVID-19 vaccine:

First Name: _____ Last Name: _____ Relationship to minor: _____

BELOW FOR ADMINISTRATIVE USE ONLY

Route IM:	○ Left	○ Deltoid	**Administration Dose (Check One):**	
	○ Right	○ Vastus Lateralis	○ 6mo-11yr Moderna (2023-2024) 0.25mL/25µg (Green) Vial	
Moderna/Spikevax COVID-19 (2023-2024) Lot#:			○ 12yr + Spikevax (2023-2024) 0.5mL/50µg (Blue) Vial	
			○ 12yr + Spikevax (2023-2024) 0.5mL/50µg (Blue) Pre -Filled Syringe	
Vaccine Administrator Signature:	**Administration Date:**	**Title:**	**Immunocompromised:**	
			○ Yes	○ No

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

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