Ashland Family Practice: COVID-19 Screening and Consent- PLEASE **PRINT** LEGIBLY

Recipient Name: _____ Date of Birth:_____

Address:_____City:_____St:_____Zip:_____

Gender: M / F / X **Race/Ethnicity:** White ____Hispanic ____ Black or African ____ **Language:_____**

If you have not received a vaccine in Oregon before please give Mother's maiden name_____

Screening Questions (circle one):

1. Are you feeling sick today? (Please answer on the day of clinic) **Y N**

2. Have you ever received a dose of COVID-19 vaccine? **Y N**
If yes, which vaccine product did you receive? …**Pfizer … Moderna … Another product_____**

3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures, Polysorbate, or a previous dose of COVID-19 vaccine? **Y N**

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) **Y N**

5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies**. Y N**

6. Have you received any vaccine in the last 14 days? (No vaccines 2 weeks prior or after) **? Y N**

7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the last 90 days? **Y N**

9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? (This does not exclude you) **Y N**

10. Do you have a bleeding disorder or are you taking a blood thinner? (This does not exclude you) **Y N**

11. Are you pregnant or breastfeeding? **Y N** *(*If so consult your obstetric provider to discuss risks and benefits).

Consent:

I have read or had explained to me the information provided in the Emergency Use Authorization Factsheet about COVID-19 Vaccine. I have had opportunity to ask questions and they were answered to my satisfaction. I understand the benefits and risks of COVID 19 Vaccine and ask that the vaccine be administered to me or the person listed above for whom I am authorized to request.

Signature _____ Date: _____

Administration:

Administered by:_____ Moderna Lot #: _____ Exp: _____ Site: R / L Deltoid