HOPE Staff - Circle
Administration Site:
LEFT or **RIGHT**
Arm/Deltoid

Last Name ________________ **First Name** _________________ **DOB** ________________

HOPE Clinic COVID-19 Immunization Screening and Consent Form

1. I have the read the MODERNA COVID-19 Emergency Use Authorization Fact Sheet
   Yes No
2. I am part of Texas Phase 1b Vaccine Priorities:
   •People 65 years of age and older Yes No
   •People 18 years of age and older with at least one chronic medical condition that puts them at increased risk for severe illness from the virus that causes COVID-19, such as but not limited to:•Cancer •Chronic kidney disease• COPD (chronic obstructive pulmonary disease) •Heart conditions, such as heart failure, coronary artery disease or cardiomyopathies •Solid organ transplantation• Obesity and severe obesity (body mass index of 30 kg/m2 or higher) •Pregnancy •Sickle cell disease •Type 2 diabetes mellitus
   Yes No
3. History of a severe allergic reaction (e.g., anaphylaxis) to any vaccine that required medical attention in the past? Yes No
4. History of a severe allergic reaction (e.g., anaphylaxis) to any injectable medicine that required medical attention in the past? Yes No
5. History of a severe allergic reaction (e.g., anaphylaxis) to any food, insect, latex that required medical attention in the past? Yes No
6. History of allergy to the following ingredients: The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG]2000dimyristoylglycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. Yes No
7. Do you have any of the following health conditions/situations:
   a. High fever or severe illness in the past 7 days? Yes No
   b. Bleeding disorder or are on a blood thinner? Yes No
   c. Immunocompromised or are on a medicine that affects your immune system? Yes No
   d. Pregnant or plan to become pregnant? Yes No
   e. Breast feeding? Yes No
8. Received another COVID-19 vaccine? Yes No If yes, please fill the follow blanks
   a. Date of Vaccine ______________________
   b. Select Brand of Vaccine Received ___PFIZER ___MODERNA
9. Have you had a positive COVID test? Yes No If yes, please fill the following blanks

a. Date of Positive test __________________

10. Have you received any other vaccinations in the past 14 days including flu shot? Yes No
11. Have you received convalescent plasma for SARS-CoV-2 (COVID) in the last 90 days? Yes No
12. Have you received monoclonal antibody for SARS-CoV-2 (COVID) in the last 90 days? Yes No

13. Vaccine Administration Consent: I request that the COVID-19 vaccination be given to me. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I agree to immediately report any significant adverse reaction to my primary care physician. I agree to continue safety practices such as wearing a face mask, social distancing, and frequent hand washing. I understand that protection against COVID-19 may not be effective until at least 14 days after the second dose. I agree to receive the second dose of COVID-19 vaccine in 28 days from the first dose. I understand the benefits and risks of the vaccination.

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Recipient (Signature)

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Print Name

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Date / Time