



Moderna COVID-19 Vaccine Consent Form

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: Male Female Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> None Specified <input type="checkbox"/> Refused	Hispanic Ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused
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HEALTH HISTORY

	<u>YES</u>	<u>NO</u>	<u>UNKNOWN</u>
1. Are you feeling sick? Or, were you exposed to a confirmed COVID-19 patient, in quarantine for COVID exposure, or tested positive for COVID in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a severe allergic reaction (ex. anaphylaxis)? For example, a reaction for which you were treated with epinephrine or an Epi-Pen or for which you had to go to the hospital. Allergy _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after any vaccination or injectable medication, including vaccine components such as lipid nanoparticles or polyethylene glycol (PEG)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever received a dose of COVID-19 vaccine? Date _____ Manufacturer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past 14 days, have you received any other vaccines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you received passive antibody therapy as a treatment for COVID-19 in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you under age 18?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you breastfeeding or pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONSENT AND RELEASE STATEMENT

I wish to receive a vaccination against COVID-19. I, the undersigned, certify that I am (a) the patient and at least 18 years of age, (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age, or (c) authorized to consent for the vaccination for the patient named above. I voluntarily give consent for Ashley Pediatrics or Industrial Health Works to administer the COVID-19 vaccine and understand this product has not been approved or licensed by the FDA but has been authorized for emergency use by the FDA under an emergency use authorization. I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital. I hereby release and hold harmless Ashley Pediatrics or Industrial Health Works for any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

SIGNATURE _____ DATE _____

For Office Use Only:

Manufacturer: Moderna	Lot #	Route: Intramuscular
Dose number <input type="checkbox"/> 1 or <input type="checkbox"/> 2	*Exp. Date: ___ / ___ / ___	*Date Administered: ___ / ___ / ___
Administered by:	Vaccine Administration Clinic:	Injection Site (Deltoid) <input type="checkbox"/> L <input type="checkbox"/> R
		Vaccine Dose: 0.5 ml



ImmTrac2 Immunization Registry
DISASTER INFORMATION
RETENTION CONSENT FORM



(Please print clearly)

Client's Last Name grid

Client's Last Name

Client's First Name grid

Client's First Name

Client's Middle Name grid

Client's Middle Name

Client's Date of Birth grid

Client's Date of Birth

*A parent, legal guardian or managing conservator must sign this form if the client is younger than 18 years of age.

Client's Gender: Male Female

Client's Address grid

Client's Address

Apartment # grid

Apartment #

Client's Telephone grid

Client's Telephone

City grid

City

State grid

State

Zip Code grid

Zip Code

County grid

County

Mother's First Name grid

Mother's First Name (if client is younger than 18 years of age)

Mother's Maiden Name grid

Mother's Maiden Name (if client is younger than 18 years of age)

ImmTrac2, the Texas immunization registry, has been designated as the disaster-related reporting and tracking system for immunizations, antivirals, and other medications administered to individuals in preparation for, or in response to, a disaster or public health emergency.

The Texas Department of State Health Services (DSHS) encourages your voluntary participation in the Texas immunization registry.

Consent for Retention of Disaster-Related Information and Release of Information to Authorized Entities

I understand that, by granting the consent below, I am authorizing retention of my (or my child's) disaster-related information by DSHS beyond the 5 year retention period.

- a state agency, for the purpose of aiding and coordinating communicable disease prevention and control efforts, and / or
a physician or other health-care provider legally authorized to administer immunizations, antivirals, and other medications, for treating the client as a patient;

I understand that I may withdraw this consent to retain information in the ImmTrac2 Registry beyond the 5 year retention period and my consent to release information from the Registry, at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group - MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent to retain my disaster-related information (or my child's information if younger than age 18) in the Texas immunization registry beyond the 5 year retention period.

Client (or parent, legal guardian, or managing conservator): Printed Name:

Date: Signature:

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you.

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.
Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com • ImmTrac2 DC
Texas Department of State Health Services • ImmTrac2 Group - MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2

Please enter client information in ImmTrac2 and affirm that consent has been granted.

DO NOT fax to ImmTrac2. Retain this form in your client's record.



COVID-19 PATIENT QUESTIONNAIRE

- YES NO 1. Have you been exposed to a COVID-19 suspected or infected person?
- YES NO 2. Have you traveled in the last month?
- YES NO 3. Have you had any family or friends visit or have you visited any family or friends recently?
- YES NO 4. If you visited family or friends, did everyone "social distance" and wear a face mask?
5. Have you developed any of these symptoms recently? Mark all that apply.
- Fever
 - Chills
 - Cough
 - Shortness of breath or difficulty breathing
 - Fatigue
 - Muscle weakness or body aches
 - Headache
 - New loss of taste or smell
 - Sore throat
 - Congestion or runny nose
 - Nausea or vomiting
 - Diarrhea

Patient Name _____ Date of Birth _____

Home Address _____

Phone _____ Alternate Phone _____

Emergency Contact & Phone _____

Preferred Pharmacy & Phone _____

I, the undersigned, certify that I have given true, accurate, and complete information on this questionnaire to the best of my knowledge.

Patient/Guardian Signature _____ Date _____