Public Health - Idaho North Central District
215 10th St.
Lewiston, ID 83501
(208) 799-3100

Moderna COVID-19 Vaccine

☐ **1st Dose (0011A)** ☐ **2nd Dose (0012A)**

VACCINE ADMINISTRATION RECORD & MEDICARE/INSURANCE AUTHORIZATION

The doctor or clinic may keep this record in your medical file or your child's medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that these immunizations will be entered in Idaho's Immunization Reminder Information System, a voluntary registry for the purposes of maintaining an immunization record accessible by health care providers in Idaho. Should I chose to have my information removed from the system, I understand it is my responsibility to contact the Idaho Immunization Program to complete this process.

"I have read or have had explained to me the vaccine information about Moderna COVID-19 Vaccine for the year 2021. I have had a chance to ask questions. I believe I understand the benefits and risks of the Moderna COVID-19 Vaccine and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request."

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I request that payment of authorized Medicare/insurance benefits be made on my behalf to Public Health – Idaho North Central District for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

PLEASE COPY FRONT AND BACK OF ALL INSURANCE, MEDICAID, AND MEDICARE CARDS AND STAPLE TO THIS CONSENT FORM.

All shaded areas must be filled out completely.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (*PLEASE PRINT*)		
Name: Last, First, MI	**Gender** ☐ **M** ☐ **F**	**Date of Birth:**
Address: Street (MAILING ADDRESS)		
City, State, Zip		**Phone #**
Race: ☐ **Black** ☐ **White** ☐ **Asian** ☐ **American Indian** ☐ **Alaska Native** ☐ **Native Hawaiian** ☐ **Other Pacific Islander** ☐ **Other, Specify:** _____	**Ethnicity:** ☐ **Hispanic/Latino** ☐ **Non-Hispanic/Latino**	
Signature of person to receive vaccine or person authorized to make the request (parent or guardian): **X**_____ **Date** _____		

For Clinic/Office Use Only	
	Date Vaccine Administered:
Signature/Title of Vaccine Administrator **X** _____	**Injection Site:** **0.5 ml** **DELTOID** **R** **L**

Pre-Vaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
8. Do you have a bleeding disorder or are you taking a blood thinner?			
9. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists