RIVERSIDE MEDICAL CLINIC
Legendary Care™

COVID-19 VACCINE SCREENING AND CONSENT FORM

Last Name: _____ First Name: _____ Birth Date: _____

Address: _____ Phone #: _____

Emergency Contact: _____ Emergency Phone #: _____

Please delay vaccination if you presently have COVID-19 or if you have any symptoms of COVID-19 suspected or confirmed.

COVID-19 Screening Questions

	Yes	No
Have you ever received a COVID-19 Vaccine?		
If yes, which one? _____		
Have you received any vaccine in the last 14 days?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
Are you feeling sick today?		
Have you tested positive for COVID-19 in the last 14 days?		
Are you pregnant or breastfeeding?		
Have you ever had a severe 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.)		
• Have you ever had an allergic reaction to another vaccine(other than COVID-19) or an injectable medication?		
• A component for the COVID-19 vaccine, including polyethylene glycol(PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.		
• Polysorbate		
• A previous dose of COVID-19 vaccine		
If yes please list: _____		

Consent for Vaccination

I have been given and have read or have had explained to me, the information in the "FACT SHEET FOR RECIPIENTS AND CAREGIVERS" (WWW.FDA.GOV/MEDIA/144414/DOWNLOAD) (WWW.CDC.GOV/CORONAVIRUS/2019-ncov/vaccines/different-vaccines/Moderna.html). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me or the person named for whom I am authorized to make this request.

- ✓ I have understood the information provided to me about the COVID-19 vaccine
- ✓ I am aware of the possible side effects
- ✓ I have had a chance to ask any questions
- ✓ I consent to receive the COVID-19 vaccine
- ✓ I am aware I must wait the minimum of 15 minutes after vaccination. (If known allergic reaction 30 Minutes)
- ✓ I have been provided post vaccine instructions

Sign: _____ Date: _____

For additional information on COVID-19 vaccine clinical guidance see: https:www.cdc.gov/vaccines/covid-19info-by-product/clincal-considerations.html - Or- www.modernatx.com/covid19vaccine-eua/providers/faq

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) 1-800-822-7967 or report online to https://caers.hhs.gov/reportevent.html. To sign up for V-safe visit: www.cdc.gov/vsafe

If you experience severe allergic reaction call 911

Clinic Use Only:

Product: Moderna Pfizer-BioNTech COVID-19 Other _____ Lot # _____

Site: _____ Given by: _____ Date: _____