Logo, company name

Description automatically generated**COVID-19 mRNA Vaccine Consent for 1a1, 1a2, and 70 years of age and older recipients**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **The following questions will help determine if there is any reason you should not receive a COVID immunization injection.**  *If a question is not clear, please ask a healthcare provider to explain.* **Questions should be answered for the person to be vaccinated.** | | | |
| 1. | Ever received a COVID-19 vaccine?......................................  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­\_\_\_\_\_\_ Manufacturer: \_\_\_ Moderna \_\_\_ Pfizer | Yes | No |
| 2. | History of any immediate allergic reaction, of any severity, after a previous dose of mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG]) or polysorbate? *See page 2 for vaccine ingredients.* **[refer to CDC CS321629E pages 3-6, 1/5/21]**  **Cause/Reaction**: | Yes | No |
| 3. | History of immediate allergic reaction of any severity to any substance?  **Cause/Reaction**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **[If Yes, observe for 30 minutes, refer to CDC CS321629E pages 3-6, 1/5/21]** | Yes | No |
| 4. | **SICK** today, including symptomatic or asymptomatic infection with COVID-19? | Yes | No |
| 5. | Received **any vaccine** in the past 14 days? | Yes | No |
| 6. | Received passive antibody therapy for COVID-19 in the past 90 days? | Yes | No |
| 7. | Have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?’ | Yes | No |
| 8. | Have a bleeding disorder or take a blood thinner? | Yes | No |
| 9. | Pregnant or breastfeeding? | Yes | No |
| 10. | Age of patient: (please type or print clearly) |  |  |

**Request for Administration of COVID-19 Vaccine for the above-named recipient:** I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and the UTK Student Health Center’s notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to myself or the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine’s success. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

I hereby release the UTK Student Health Center, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. ***This consent is valid for 12 months from date signed.***

**PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**=====================INFORMATION BELOW THIS LINE MUST BE TYPED===================**

**Interpreter:**  Yes |  No | **Cell Phone:** Click or tap here to enter text.

**Hispanic:**  Yes |  No | **Alt. Phone:** Click or tap here to enter text.

**LAST Name (legal):** Click or tap here to enter text. **Middle Initial:** Click or tap here to enter text.

**First Name (legal):** Click or tap here to enter text. **Sex:** Male  Female   
**DOB:**Click or tap to enter a date. **Race:**  Asian **|**  Black **|**  White **|**  American Indian **|**  Pacific Islander **|** Other

**Street Address:**Click or tap here to enter text.

**City:** Click or tap here to enter text. **Zip Code**:Click or tap here to enter text. Revised 2/1/2021

|  |
| --- |
| **\*\*\*\*\* DO NOT MARK\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* THESE BOXES ARE FOR OFFICIAL USE ONLY \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* DO NOT MARK \*\*\*\*\*** |
| **Med Review/Counseled:** Vaccine spacing Pregnancy Breastfeeding Weakened immunity Blood disorder |
| **Data Processing Status:** RegistrationEncounterVaccineScan |

Mfr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_

LOT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Site: (Circle one) Left Deltoid Right Deltoid Other Route: IM

Date Given: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ EUA Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider ID: \_\_\_\_\_\_\_\_\_\_\_\_\_

Mfr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_

LOT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EXP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Site: (Circle one) Left Deltoid Right Deltoid Other Route: IM

Date Given: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ EUA Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider ID: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Dose 1- Official Use Only Only**

**Dose 2- Official Use Only Only**

Logo, company name

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**COVID-19 mRNA Vaccine Consent (Continued)**

**Each dose of the Moderna COVID-19 Vaccine contains the following ingredients:**

* messenger ribonucleic acid (mRNA)
* lipids:
  + SM-102
  + polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG]
  + cholesterol
  + 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC])
* tromethamine
* tromethamine hydrochloride
* acetic acid
* sodium acetate
* sucrose