Crawford County Health Department
COVID-19 Vaccine Consent Form

Section 1: Patient Information (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **month_____ day_____ year _____ Age: ____**
ADDRESS			**DAYTIME PHONE NUMBER:**
CITY	**STATE**	**ZIP**	**PHYSICIAN:**

	YES	NO
1. Do you feel sick today (e.g., cold, fever, acute illness)? If yes, defer vaccination until after illness.	☐	☐
2. Have you received any vaccinations in the past two weeks? If yes, defer vaccination until >14 days.	☐	☐
3. Do you have an allergy to latex or any of the ingredients of the Moderna COVID-19 vaccine? 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, and 1,2-disteraroyl-sn-glycero-3-phosphocholine [DSPC], tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.	☐	☐
4. Have you ever had a serious reaction, after receiving a vaccination? **If yes, you will need to stay 30 minutes for observation after vaccination.	☐	☐
5. Have you ever had an anaphylactic reaction at any time, including post-vaccination? **If you have had a severe allergic reaction after a previous dose of the Moderna COVID-19 vaccine, you should NOT get the vaccine.	☐	☐
6. Do you have a history of a bleeding disorder or are on a blood thinner? **If yes, a physician consult is necessary prior to taking the vaccine.	☐	☐
7. Are you immunocompromised or on a medicine that affects the immune system? **If yes, a physician consult is necessary prior to taking the vaccine.	☐	☐
8. Have you received passive antibody therapy as treatment for COVID-19? **If yes, defer for 90 days from treatment.	☐	☐
9. Have you received any other COVID-19 vaccine? Manufacturer:_____ Date given: month_____day_____year_____	☐	☐
10. I am pregnant or breastfeeding, and I have been counseled by my Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine.	☐	☐ N/A

Section 2: Consent

CONSENT FOR VACCINATION:

- **I GIVE CONSENT** to Crawford County Health Department and its staff to vaccinate me with this vaccine. I will not hold Crawford County Health Department or the individual vaccinating me responsible for any adverse reaction that may result from this vaccination.
- I have read the Fact Sheet for Emergency Use Authorization of the Moderna COVID-19 vaccine and understand the risks and benefits.
- I have been provided information on VaxText COVID-19 Vaccination Second-Dose Reminder and V-Safe, a safety monitoring smartphone-based tool managed by CDC.
- I consent to allow Crawford County Health Department to release information regarding my vaccinations to my physician and the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). I have been provided with Notice of Privacy Practices.
- I understand that I must stay for an observation of 15 or 30 minutes as instructed by the vaccine administrator.

Signature: _____

Date: **month_____day_____year_____**

FOR ADMINISTRATIVE USE ONLY

Date Dose Administered	Route	Site	Vaccine Manufacturer	Lot Number/ Expiration Date	Name and Title of Vaccine Administrator
	IM	R Deltoid L Deltoid	Moderna	Lot #:_____ Expiration Date: _____	

Insurance Information: ****PLEASE PRESENT INSURANCE CARD(S) TO CLERK ****

Primary Insurance Information

Medicare Part B-Primary ID# _____

Write name exactly how it appears on Medicare card

_____

Insurance Co.: _____ ID#: _____

Group#: _____

Name of Policyholder: _____ Date of Birth:

_____/_____/_____

Social Security #: _____-_____-_____

Address of Policyholder (if different from patient):

_____

Do you also have Medicaid? Y or N If Yes, do you pay a premium? Y or N

If, Y enter Medicaid ID # _____ (9-digit number beside name on Medicaid card)

Do you have Secondary Ins? Y or N If Yes Ins. Co _____