MODERNA COVID-19 Vaccine Administration Record

Please Print Information about person to receive vaccine

Last name	**First**	**Middle initial**	**Birth date**	**Age**
Street address		**City**	**Zip code**	
Telephone #				
Male ☐ **Female** ☐ **Email address:**				

I have read or have had explained to me the information in the Emergency Use Authorization (EUA) about the COVID-19 vaccine. I believe I understand the benefits and risks of the COVID-19 vaccine and ask that the COVID-19 vaccine be given to me or the person named above for who I am authorized to make this request. I authorize billing of the administration of vaccination to Medicare, Medicaid, or insurance. I hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Macon County Health Department dated 9/23/2013. _____ (initials)

CDC recommends waiting 15 minutes after receiving immunizations.

Signature of person to receive the COVID-19 vaccine, or the person authorized to make request:

X_____ Date: _____

Office use only

☐ **Dose # 1** Manufactured by: Moderna EUA given: _____ Site of vaccine: right left deltoid Date Administered: / / Lot #:	☐ **Dose # 2** Manufactured by: Moderna EUA given: _____ Site of Vaccine: right left deltoid Date Administered: / / Lot #:

Clinic/office address: Macon County Health Department, 1221 E Condit St, Decatur, IL 62521

Signature & Title of Vaccine Administrator_____

Medicare #_____

Medicaid #_____

Insurance:
Member ID/Group # _____

Screening Checklist for Contraindications to the MODERNA COVID-19 Vaccination

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you the MODERNA vaccination today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Has the person to be vaccinated ever had a severe allergic reaction to any vaccine or injectable (intramuscular, intravenous, or subcutaneous) in the past?	☐	☐	☐
3. Has to person to be vaccinated previously been infected with COVID-19 and received monoclonal antibodies or convalescent plasma as part of treatment in the last 90 days? (must be minimum 90 days since treatment)	☐	☐	☐
4. Is the person to be vaccinated today pregnant or breastfeeding?	☐	☐	☐
5. Has the person to be vaccinated today previously received a COVID-19 vaccine?	☐	☐	☐

Form Completed by _____ Date _____

Form Reviewed by _____ Date _____

(www.immunize.org) Technical content reviewed by CDC