# MONTGOMERY COUNTY HEALTH DEPARTMENT
# 2021 COVID VACCINATION – **ON-LINE FORM**
## **(MODERNA-INJECTABLE)**

| **NAME** (Last) | **(**First) | (M.I.) | **DATE OF BIRTH** | **AGE** | **RACE** | **Gender** |
|---|---|---|---|---|---|---|
| | | | | | | |

| **In Address - Physical** | **Phone Number: □ Mobile □ Home** |
|---|---|
| | |

| **CITY** | **STATE COUNTY** | **ZIP** | **Ethnicity**<br>**□ Hispanic**<br>**□ Non-Hispanic** |
|---|---|---|---|
| | | | |

| **Employer's Name/Organization/ Facility you reside in** | **Email:**<br><br>**□Does not have email**<br><br>**Preferred Language**<br>**□ English**<br>**□ Spanish**<br>**□ Other _____** | **Communication Preference**<br>**□ Email**<br>**□SMS**<br>**□ Both**<br>**□None** | **Essential Frontline Worker (Police, Food Processing, Teacher etc.)**<br>**□ Yes**<br>**□ No**<br>**Do you reside or work in long-term care/assisted living facility?**<br>**□ Yes**<br>**□ No** |
|---|---|---|---|
| | | | |

| **Please mark YES or NO for each question.** | **YES** | **NO** |
|---|---|---|
| 1. Are you feeling sick today? | | |
| 2. Have you ever received a dose of COVID-19 vaccine?<br>*If yes, which vaccine product?<br>□Moderna □ Pfizer<br>□ Another Product _____ | | |
| 3. Have you had a severe allergic reaction to: **Answer all**<br>(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.)<br>• A component of COVID-19 vaccine, **including polyethylene glycol (PEG),** which is found in some medications, such as laxatives and preparations for colonoscopy procedures<br>• **Polysorbate**<br>• **A previous dose of COVID-19 vaccine.** | | |
| 4. Have you ever had an allergic reaction to another vaccine (other than COVID_19 vaccine) or an injectable medication | | |
| 5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to food, pet, environment, or oral medication allergies. | | |
| 6. Have you received any vaccine in the last 14 days? | | |
| 7. Have you ever had a positive test for COVID-19 or has a doctor told you that you had COVID-19 | | |
| 8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | |
| 9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | |
| 10. Do you have a bleeding disorder or taking blood thinner? | | |
| 11. Do you have any medical conditions known to increase risk of severe illness? i.e.<br>Diabetes, COPD, Asthma, Cancer, Cerebrovascular Disease, Kidney Disease, Cystic Fibrosis, Hypertension, Immunocompromised from solid organ transplant, Liver Disease, Immunocompromised State (weakened immune system), Liver Disease, Neurologic condition such as dementia, Obesity, Overweight, Pregnancy, Pulmonary Fibrosis, Sickle Cell, Smoker, Thalassemia (a type of blood disorder)<br>How many conditions do you have that increase risk of severe illness from COVID-19?<br>□ None<br>□ 1<br>□ 2 or more | | |

Vaccine Recipients Name:_____

**COVID VACCINATION QUESTIONAIRE CONTINUED**

| **Please mark YES or NO for each question.** | **YES** | **NO** |
|---|---|---|
| 12. Are you pregnant or breastfeeding? | | |
| 13. In the past 2 weeks have you had a fever, coughing, shortness of breath? | | |
| 14. Have you or anyone in your household been tested for COVID19 in the last 30 days? | | |
| 15. Have you recently traveled to/from an area with COVID-19? | | |

**Vaccination Consent**

□ I certify that I am: (a) at least 18 years of age (b) a parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further I herby give my consent to the licensed healthcare provider administering the vaccine as applicable, to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include shortness of breath, hoarseness of wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient should contact a healthcare provider immediately.

□ I have reviewed the V-Safe after vaccination heath checker at
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html

□ I have reviewed the recipient fact sheet for Moderna Vaccine
www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf

□ I have reviewed the above information which provides me with the benefits and potential adverse reaction and I provide my consent to receive the vaccine.

_____ _____

Signature of Vaccine Recipient Date

**Provider Use Only:**

| Vaccine | Date Dose Administered | Route/Site | Dosage | Vaccine Manufacturer | Lot Number | Name and Title of Vaccine Administer |
|---|---|---|---|---|---|---|
| 2021 MODERNA NDC 80777-0273-99-5010700 | / /<br>□Dose 1 | Intramuscularly<br>Left Right<br>Deltoid | 0.5ml | MODERNA | | |

| Vaccine | Date Dose Administered | Route/Site | Dosage | Vaccine Manufacturer | Lot Number | Name and Title of Vaccine Administer |
|---|---|---|---|---|---|---|
| 2021 MODERNA NDC 80777-0273-99-5010700 | / /<br>□ Dose 2 | Intramuscularly<br>Left Right<br>Deltoid | 0.5ml | MODERNA | | |

Updated 01-22-2021