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

DATE:_____

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

In Address - Physical	**Phone Number: □ Mobile** ***Required □ Home**	
CITY	**STATE COUNTY**	**ZIP**	**Ethnicity** **□ Hispanic** **□ Non-Hispanic**
Insurance Coverage **Complete your coverage information. Please attach a copy of your card.**	**□PRIVATE INSURANCE** **CARRIER/ID#/GROUP#**	**□MEDICAID** **ID NUMBER:**	**□MEDICARE** **ID#** **□OTHER SUPPLEMENT/NAME/ID#**
Employer's Name/Organization/ Facility you reside in	**Email:** **□Do not have email** **Preferred Language** **□ English** **□ Spanish** **□ Other _____**	**Communication Preference** **□ Email** **□SMS** **□ Both** **□None**	**Essential Frontline Worker (Police, Food Processing, Teacher etc.)** **□ Yes** **□ No** **Do you reside or work in long-term care/assisted living facility?** **□ Yes** **□ 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? *If yes, which vaccine product? □ Moderna □ Pfizer □ Janssen (Johnson & Johnson) □ Another Product_____		
3. Have you had a **severe allergic reaction** to: **Answer all questions** (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.)		
• A component of COVID-19 vaccine, **including polyethylene glycol (PEG),** which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
• **Polysorbate,** which is found in some vaccines, film coated tablets, and intravenous steroids.		
• **A previous dose of COVID-19 vaccine.**		
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID – 19 component, but it is not known which component elicited the immediate reaction.		
4. Have you ever had an allergic reaction to another vaccine (other than COVID_19 vaccine) or an injectable medication (This would include a severe allergic reaction as stated above)		
5. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to food, pet, venom, 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 dermal fillers?		

Vaccine Recipient's Name_____

Please mark YES or NO for each question.	**YES**	**NO**
12. Do you have any medical conditions known to increase risk of severe illness? i.e. 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 How many conditions do you have that increase risk of severe illness from COVID-19? □ None □ 1 □ 2 or more		
13. Are you pregnant or breastfeeding?		
14. In the past 2 weeks have you had a fever, coughing, shortness of breath?		
15. Have you or anyone in your household been tested for COVID19 in the last 30 days?		

Vaccination Consent – Please check all boxes that apply.

□ 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	/ / □Dose 1	Intramuscularly Left Right Deltoid	0.5ml	MODERNA		
	Date Dose Administered	Route/Site	Dosage	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administer
	/ / □Dose 2					

Updated 01-22-2021 /Revised 02-04-2021, Revised 3/9/2021