CommunityCare Clinics
Minnesota

COVID-19 VACCINE SCREENING AND AGREEMENT FOR BOOSTER ( ) OR FIRST SECOND AND THIRD DOSE FOR MODERNA

Contact information – person being vaccinated.

Last name: _____first name: _____Middle-IN ____

Age_____

Date of Birth ___ /_____ /_____

Primary phone number: _____

Address (street or P.O. Box):

_____

City: _____

State: _____

ZIP code: _____

Mother's name (last, first, middle - if younger than 18 years):

_____

Mother's maiden name (if younger than 18 years): _____

Agreement

By signing below, I understand, recognize, approve, and agree that:

- I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: [Pfizer-BioNTech vaccine/Moderna vaccine].
- I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
- I agree to receive the COVID-19 vaccine for myself or for the person named above.

Signature of patient or parent/guardian: _____

Date: _____/ _____ /_____

_____Information collected on this form will be used to document that you have received vaccine(s). Information about your vaccine(s) may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it.

Health history:

Yes	No	Unknown	Question
Yes	No		Did you get a two Covid-19 Vaccine series 6 months ago? • **18 years and older for Moderna**
Yes	No		Are you immunocompromised? **You Will get 0.5ml/100 mcg full dose vaccine if yes and 0.25ml/50 mcg dose if no.**
Yes	No	Unknown	Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a component of the COVID-19 vaccine?
Yes	No	Unknown	Immediate allergic reaction (within 4 hours) of any severity to a previous COVID-19 vaccine dose or known (diagnosed) allergy to a component of the vaccine or any of its ingredients ?
Yes	No	Unknown	Immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous)? Does not include allergy shots.
Yes	No	Unknown	Are you feeling sick today?
Yes	No	Unknown	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?
Yes	No	Unknown	Exposed to another person with known COVID-19 disease?
Yes	No	Not applicable	Did you have a delayed allergic reaction at the injection site (e.g., redness, itching) after the two doses of COVID-19 vaccine?
Yes	No	Unknown	Have you received any other vaccines (that were not COVID-19 vaccine) within the past 14 days?
Yes	No	Not applicable	Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medication, foods, vaccinations, or latex? **30-minute post vaccination wait required.**

DO NOT WRITE BELOW THIS LINE

Vaccine information

COVID-19 Vaccine Presentation	EUA Fact Sheet Date	Route	Manufacturer	Lot Number	Admin Site	Person Admin
COVID-19 (Pfizer)		IM	Moderna		Left deltoid/ Right deltoid	

1. **COVID-19 Vaccine Presentation** = Moderna

Signature of person (or clinic) administering vaccine:
_____(Odam Medical Group/CCC-MN)

Date administered: ___/___/_____