Administration Facility Name/Facility ID: Young County Family Clinic/Graham Regional Medical Center

COVID-19 VACCINE SCREENING AND CONSENT FORM
Moderna COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last:	First:	Middle Initial:	
Date of Birth: Month Day Year	**Mobile Phone Number (Patient or Guardian):** ( )		
Address:	Apt/Room #:		
City:	State:	Zip:	
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Islander ☐ Unknown		**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or No for each question.	Yes	No
1. Are you sick today?		
2. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		
3. In the past two weeks, have you tested positive for COVID-19?		
4. Have you ever had a severe allergic/anaphylactic reaction to a vaccine, medication, or food?		
5. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Young County Family Clinic to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Young County Family Clinic/Graham Regional Medical Center and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies (including ImmTrac2, the Texas Vaccine Registry).
- I further authorize Young County Family Clinic/Graham Regional Medical Center or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Young County Family Clinic/Graham Regional Medical Center or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if I receive an invoice after the time of service, upon receipt of such invoice.

Signature of Patient or Authorized Representative_____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

VACCINE DOCUMENTATION – To be completed by GRMC/YCFC Clinical Staff ONLY

Date of Vaccine	Site of Injection	Vaccine Mfg.	Lot Number	Expiration Date	Dose # (1 or 2)	Given By: