Moderna COVID-19 Vaccine Consent Form

Name of Recipient **(PLEASE PRINT CLEARLY)**_____

Email_____ Sex: ☐ Male ☐ Female Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
MM DD YEAR

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____ County:_____

For ImmTrac2 State Use:

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ White ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

FOR MEDINA HEALTHCARE SYSTEM EMPLOYEES, PERSONNEL and AFFILIATES ONLY

☐ MHS Employee ☐ External Physician/Medical Contractor/NP/PA ☐ Contractor ☐ Other:

Department_____ Hospital_____ Clinic:_____

I declare that I am 18 years of age or older. I further declare that I:

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
3. Am not currently sick with a fever, active respiratory infection or other moderate/severe illness.
4. Have not had COVID-19, received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
5. To my knowledge, am not allergic to the following ingredients in the COVID-19 vaccine: mRNA, lipids((4-hydroxybutyl)azanediyl)bis(hexane-6, 1-diyl) bis(2-hexyldecanoate), 2[(polyethylene glycol)-2000]-N, N-ditetradecylacetamide, 1, 2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate and sucrose.

I understand that if I have any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine.
I further declare that if I have any of the following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine:

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I agree to WAIT in the vaccine administration location for 15 minutes after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT in the vaccine administration location for 30 minutes after receiving the vaccine.

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Medina Healthcare System. Medina Healthcare System's officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge and in consideration of Medina Healthcare System giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless Medina Healthcare System, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. Medina Healthcare System makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I have read and understood "What To Do If You Have A Reaction To The COVID-19 Vaccination" and the "Fact Sheet" by the FDA regarding the COVID-19 Vaccination. I further understand and agree that Medina Healthcare System is required to submit COVID-19 vaccine administration data to the Texas Immunization Information System (VIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of Medina Healthcare System to give me a COVID-19 vaccine.

Signature of Patient/Parent:_____ **Date:**_____

Moderna Lot # & Vial Exp.
Lot # _____

Vial Exp. Date_____

Route ☐ IM ☐ RD ☐ LD

Administered by (legal signature and title)

_____

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WHAT TO DO IF YOU HAVE A REACTION TO THE COVID-19 VACCINATION

- Most people have side effects from the vaccination, but these usually only last 24 – 48 hours after receipt of the vaccination. A few people may have no side effects at all. Most people will experience pain, redness and/or soreness at the injection site. Many people will have a headache, fever, chills, muscle pain and/or fatigue from the vaccine, particularly after the second dose. A few people will have nausea or swollen lymph nodes (lymphadenopathy).
- In rare circumstances, the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness).

What should you do if you have a reaction?

If you experience any of the following:

- Red, sore arm at and around the injection site:
  - Apply an ice pack to the affected area for comfort.
  - If condition does not improve or worsens in 24 to 48 hours, call your physician.
- Fever, achiness, fatigue and/or headache:
  - Take the non-prescription product that you would usually use for discomfort or fever relief as needed.
  - If condition does not improve or worsens in 24 – 48 hours, call your physician.
- Unusual or severe reaction (for example, hives, difficulty breathing, wheezing, allergic reaction):
  - Immediately call your physician, call 911 or go to the emergency room or nearest urgent care center.
- If you have seen your physician or visited the emergency room or an urgent care in relation to any of the reactions listed above, please notify Employee Health at 830-426-7848 and Billie Bell at 830-741-0656. A nurse will return your call within 24 hours.

Information about the COVID-19 Vaccine

- **The COVID-19 vaccines are <u>not</u> live virus vaccines so the vaccines cannot infect anyone with COVID-19.**
- **All needles and syringes are sterile, are one-time use and are safely discarded.**
- **According to data, the COVID-19 vaccine has approximately a 94% success rate in completely protecting those who receive it. The remainder have partial protection and will have greatly lessened symptoms if they do contract COVID-19.**
- **The vaccine will begin to provide protection about one to two weeks after the second shot of the series is given.**
- **At this time, we do not know how long the COVID-19 vaccine is effective for, so you may need future vaccines to remain protected.**
- **While the COVID-19 vaccination does provide protection against infection or greatly lessened symptoms if you contract COVID-19, you should continue to practice hand hygiene and use appropriate personal protective equipment(PPE).**