Patient Name: **Phone Number:**
Date of Birth: **Address:**
Appointment Time:

Reason for today's visit: COVID-19 Vaccination

1. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle, or body aches, etc.?	[ ]Yes	[ ]No
2. Have you EVER had a life-threatening allergic reaction after a dose of any vaccine or injectable medication?	[ ]Yes	[ ]No
3. Have you had any vaccine within the past 14 days, or do you have plan to receive another vaccine within the next 14 days?	[ ]Yes	[ ]No
4. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	[ ]Yes	[ ]No
5. Have you tested positive for COVID-19 in the last 14 days?	[ ]Yes	[ ]No
6. Are you currently in quarantine for COVID-19 exposure?	[ ]Yes	[ ]No
7. Are you pregnant or planning to get pregnant?	[ ]Yes	[ ]No

I agree to WAIT near the clinic 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 near the clinic 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 and agree to all the above and I hereby give my consent to the staff of IM Clinic and Dr Iqbal to give me a COVID-19 vaccine. I have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

Signature:

Patient Name:

Injections □ 91301– Moderna Vaccine □ 0011A– Admin 1st dose □ 0012A– Admin 2nd dose	

Dose 1 of 2 given today Vaccine Manufacturer: Moderna Lot#: 019B21A Mfg Date: 02/21/2021 Administered by: Date:	Dose 2 of 2 given today Intramuscular injection given: □ Left deltoid □ Right deltoid

F/U in	1 week	2 weeks	**1 month**	6 weeks	3 months	Nurse visit: