COVID-19 Adult Vaccine Consent Form

Name (Last, First):_____ **DOB**:_____ **Age**: _____

Phone Number: _____

Do you have the same insurance as your child? Yes No

Full name of child at the practice_____

I understand that if my insurance is different, I must provide a copy of my insurance card at time of vaccine administration.

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Black/Trinidadian
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other ☐ Decline to Answer

Ethnicity: Hispanic or Latino: ☐ Yes ☐ No ☐ Unknown ☐ Decline to Answer

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider.

1. Are you feeling sick today? _____ Yes _____ No _____Unsure

2. Have you had COVID-19 in the last 90 days? _____ Yes _____ No _____Unsure

3. Have you ever received a dose of the COVID-19 vaccine? _____ Yes _____ No _____Unsure

   a. If yes, which vaccine product(s) did you receive?
   ☐ Pfizer-BioNTech ☐ Moderna ☐ Another Product

   b. How many doses of COVID-19 vaccine have you received? _____

4. Do you have a health condition or are undergoing treatment that makes you moderately or severely immunocompromised?
   This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T- cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.

   _____ Yes _____ No _____Unsure

5. Have you received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies? _____ Yes _____ No _____Unsure

6. Have you ever had an allergic reaction to:
   (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 caused hives, swelling, or respiratory distress, including wheezing.)

   - A component of a COVID-19 vaccine? _____ Yes _____ No _____Unsure
   - A previous dose of COVID-19 vaccine? _____ Yes _____ No _____Unsure
   - Another vaccine other than the COVID-19 vaccine? _____ Yes _____ No _____Unsure
   - Any medication or food? _____ Yes _____ No _____Unsure

7. Check all that apply to you:

- ☐ History of Multisystem Inflammatory Syndrome (MICS-C or MIS-A)
- ☐ History of myocarditis or pericarditis
- ☐ History of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ History of Guillain-Barre Syndrome (GBS)
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of COVID-19 disease within the last 3 months

I have read or had explained to me the information contained in the Fact sheet for Recipients and Caregivers for Moderna 6mn - 11years and Information for Recipients and Caregivers 12 Years and Older for the COVID-19 vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions which have been answered to my satisfaction and understand the benefits and risks of the vaccine. I, on behalf of myself, my heirs, executors, and personal representatives hereby agree to release, indemnify, and hold harmless Tosa Pediatrics, its subsidiaries, affiliates, agents, owners, providers, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine.

I acknowledge disclosure of this vaccination to public health officials and other health care professionals. I understand this vaccine will be recorded in the Wisconsin Immunization Registry (WIR) for the purposes of sharing vaccination information with other health care providers and tracking vaccine inventory only.

In the event of an emergency situation, emergency medication (Epinephrine/Benadryl) and/or oxygen may be administered to me. In the event of an emergency situation, I authorize Tosa Pediatrics' staff to obtain any necessary medical care they deem necessary including but not limited to, obtaining paramedic assistance and transport to a local hospital for additional treatment or observation.

Signature _____ **Date**_____

For office use only:

Type/Lot:_____ Location:_____ Administered by:_____

DOS: _____ Provider:

TR	TM	NK	KK	JG	MN

Vaccine: ☐ 91322 Moderna 12+