What you will need to bring to the site for your vaccination:

1. Signed **consent form** (enclosed)
2. Completed **questionnaire form** (enclosed)
3. **Photo I.D.**
4. **Medicare card** (*the red, white, and blue card*). If you do not have Medicare then a copy of **insurance cards** which include Medical, Prescription & Medicaid (if applicable)
5. Face covering/mask.
6. Come dressed appropriately to receive the vaccine, easy access to the upper arm! This is an open area and no privacy screens.
7. IF THIS IS YOUR 2ND VACCINATION BRING YOUR **WHITE CDC CARD** YOU WERE GIVEN AT YOUR FIRST VACCINATION.
8. This vaccine clinic is by **appointment only**. Please **DO NOT** bring others with you.
9. **DO NOT COME EARLY**. Stay in your car and enter only at your appointment time otherwise you may be asked to return to your car.
10. I have read and understand the above guidelines.

X____

Signature

Screening questionnaire for immunization COVID-19 immunization

Date___________________________________

Name__________________________________ Gender M F Date of Birth________________

Address____
(Street) (City) (State) (Zip)

Phone___________________________ e-mail____

Ethnicity: African American Native American Asian Caucasian Hispanic or Latino
Other ___________________________Prefer not to answer____________

Are you one of the following: Essential worker____First responder____Healthcare worker____
Age 65 or older______ Age 18 to 64 with High-risk medical condition_____N/A____

Screening questionnaire for immunization:

1. In the past two weeks have you tested positive for Covid 19 or are you being monitored for COVID-19? **YES NO**
2. In the past two weeks have you had exposure to anyone who tested positive to COVID-19? **YES NO**
3. Have you had an onset of fever, chills, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of taste or smell, sore throat, nausea, vomiting or diarrhea? **YES NO**
4. Do you feel sick today? **YES NO**
5. Do you have an allergy to medications, foods, or any vaccine components(eggs, gelatin, the thimerosal, neomycin, gentamicin, latex, aluminum, preservatives, Baker's yeast? If yes, please explain____ **YES NO**
6. Have you had Covid-19 and received antibody therapy as treatment? **YES NO**
7. Have you ever had a serious reaction or fainted after receiving a vaccine? If yes, please explain____ **YES NO**
8. Have you ever had a seizure, brain disorder or Guillain-Barre Syndrome? **YES NO**
9. Are you pregnant or planning to become pregnant in the next month? **YES NO**
10. Are you taking a blood thinner beside(aspirin, warfarin, Coumadin, etc.)? **YES NO**
11. Have you received any other vaccine in the past four weeks? **YES NO**

*****Is this your: First vaccine: ___**
Second vaccine: ___ Date of first vaccine: ______________________

****STOP DO NOT FILL****

Provider use only:
Moderna COVID-19 vaccine lot number and exp date:
Location of injection: RA LA 0.25ml or 0.5ml ****Provider name:** LV FA FO FJ FC
Vaccinator Signature:

Location site:

Consent:

Name:____ Date:____________

I have been offered a copy of the FACT SHEET FOR RECIPIENTS AND CAREGIVERS and understand the FDA has authorized the emergency use of the Moderna COVID-19 vaccine, which is not an FDA approved vaccine. I understand the benefits and risks of the vaccine. I understand that I may refuse vaccination. I understand that I may be able to get a vaccine manufactured by another company at another facility if I so choose. I have had the opportunity to ask questions about the vaccine and my questions have been answered to my satisfaction. I understand the known benefits and risks of the vaccine and understand that some risks may not be known. I consent to the administration of the vaccine. I authorize information about administration of the vaccine and reactions to the vaccine to be forwarded to the Department of Health. I agreed to stay in the office/injection site area for at least 15 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, I am responsible for following up with my physician at my expense.

On behalf of myself, my heirs, and my personal representatives, I hereby release the providers administering the vaccine(Family Pharmacy of Olyphant Inc., Family Pharmacy of Archbald Inc., Family Pharmacy of Jessup Inc, Family Pharmacy of Carbondale Inc, Lords Valley Village Pharmacy Inc) and their owners, operators, administrators, employees and agents, directors, from any and all liability that might arise from this vaccination.

Under these terms, I consent to receive the Moderna COVID-19 vaccine:

X____

I authorize the provider to bill my insurance for the immunization administration only.

X____

Insurance_________________________ ID#____________________Group____________

I attest that I do not have any form of insurance. .X___________________________________