MODERNA & PFIZER
COVID-19 Vaccine PATIENT INFORMATION & CONSENT

I declare that I: (Check if Yes)

□ 1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
□ 2. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
□ 3. Has not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
□ 4. Is 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 following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine or to have my child 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 near the clinic location for 15 minutes after receiving the vaccine or if I have 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 or my child 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 Passport Health and its affiliates (collectively Passport Health). The owner and/or operator of this site, their affiliates, 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 Passport Health 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 Passport Health, 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. Passport Health 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 acknowledge receipt of Passport Health's Notice of Privacy Practices.

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 Passport Health is required to submit COVID-19 vaccine administration data to the Texas Immunization Information System, and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS)

Patient Information Section-attach photocopy of insurance (front only) and driver's license

Yes/ No Are you sick today or have you had a fever in the past 48 hours? _____/_____
Yes/ No Are you pregnant or nursing or breastfeeding? Primary **Insured ID** **Group#**
Yes/ No Do you have any allergies? List all medicine or vaccine allergies_____
Yes/ No I am giving permission to the vaccinator to provide a copy of my vaccine record (consent) to my employer if requested.

_____ _____ _____ ___/___/___ ___ ___
Patient Last Name First Name Middle I Birth Date M/D/Y Age Sex

_____ _____ _____ _____ _____ _____-_____-_____
Patient Address: Street City State County Zip Daytime Phone Number

All Patients are required to be entered into Immtrac2 (Texas vaccine registry) to receive a COVID 19- vaccine. Please provide:
Race _____ Ethnicity _____

_____ _____/ _____-_____-_____
Signature of person receiving vaccine or Guardian Emergency Contact Person/ Emergency Phone #

If you have any questions, please ask now or check with your physician before receiving the vaccine. I understand the benefits and risks of these vaccinations and request those indicated above to be given to me. If you experience any significant reactions, see your physician. Please note that by signing this form you are accepting responsibility for all costs not covered by your insurance.

For Clinic Use Only below this point:

Vaccine Administered (nurse checks box by vaccine given)	**Lot #**	**Exp** MM/YY	**Amount/Site**	**Injection Site**
COVID-19 Moderna Vaccine (circle) Dose 1 Dose 2 Dose 3			**0.5 ml >18yr IM**	**Left Right**
COVID-19 Pfizer Vaccine (circle) Dose 1 Dose 2 Dose 3			**0.3 ml >12yr IM**	**Left Right**

Nurse Signature: RN Date: PAYMENT: (CIRCLE) INSUR CASH CHECK# OTHER BILL