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Premier FORT BEND CARE

Family Medicine

Informed Consent for COVID-19 Vaccine

_____ Initial I verify that I have been provided with and have read the Emergency Use Authorization Fact Sheet for the MODERNA Covid-19 Vaccine. I acknowledge that I have had a chance to ask questions of a medical professional about the vaccine. I understand the known risks and the potential benefits of receiving the vaccine, as described in the Fact Sheet(s). I request and consent to the Covid-19 Vaccine being given to me.

_____ Initial I understand it is recommended that I remain on site for at least 15 minutes after receiving the COVID-19 Vaccine and that, depending on the recommendation of medical professionals, I may be asked to remain on site longer for monitoring.

_____ _____
Signature of Vaccine Recipient Date

_____ _____
PRINT NAME LEGIBLY Date of Birth

Address:_____

Phone No:_____Race/Ethnicity_____

_____ 1st DOSE

_____ 2nd DOSE

COVID Vaccine Manufacturer: MODERNA LOT#_____Expiration_____

Injection Site: _____Left Deltoid _____Right Deltoid

Administered By:_____

Date/Time given:_____

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