HOPE Staff-Circle
Administration Site:
Left or Right
Arm/Deltoid

Last Name _____ First Name _____ DOB_____

HOPE Clinic COVID-19 Immunization Screening and Consent Form

1. I have received and read the MODERNA COVID-19 Emergency Use Authorization Fact Sheet ☐ Yes / ☐ No
2. I am a part of Texas Phase 1b Vaccine Priorities:
   •People 65 years of age and older ☐ Yes / ☐ No
   •People 18 years of age and older with at least one chronic medical condition that puts them at increased risk for severe illness from the virus that causes COVID-19, such as but not limited to:•Cancer •Chronic kidney disease• COPD (chronic obstructive pulmonary disease) •Heart conditions, such as heart failure, coronary artery disease or cardiomyopathies •Solid organ transplantation• Obesity and severe obesity (body mass index of 30 kg/m2 or higher) •Pregnancy •Sickle cell disease •Type 2 diabetes mellitus 1.
   ☐ Yes / ☐ No
3. History of a severe allergic reaction (e.g., anaphylaxis) to any vaccine that required medical attention in the past? ☐ Yes / ☐ No
4. History of a severe allergic reaction (e.g., anaphylaxis) to any injectable medicine that required medical attention in the past? ☐ Yes / ☐ No
5. History of a severe allergic reaction (e.g., anaphylaxis) to any food, insect, latex that required medical attention in the past? ☐ Yes / ☐ No
6. History of allergy to the following ingredients: The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG]2000dimyristoylglycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. ☐ Yes / ☐ No
7. Do you have any of the following health conditions/situations:
   a. High fever or severe illness in the past 7 days? ☐ Yes / ☐ No
   b. Bleeding disorder or are on a blood thinner? ☐ Yes / ☐ No
   c. Immunocompromised or are on a medicine that affects your immune system? ☐ Yes / ☐ No
   d. Pregnant or plan to become pregnant? ☐ Yes / ☐ No
   e. Breast feeding? ☐ Yes / ☐ No

8. Received another COVID-19 vaccine? ☐ Yes / ☐ No if yes, please fill the follow blanks
    a. Date of Vaccine _____
    b. Select Brand of Vaccine Received ☐ PFIZER ☐ MODERNA
9. Have you had a positive COVID test? ☐ Yes / ☐ No
   If yes, please fill the following blanks
    a. Date of Positive test _____
10. Have you received any other vaccinations in the past 14 days including flu shot?
☐ Yes / ☐ No
11. Have you received convalescent plasma for SARS-CoV-2 (COVID) in the last 90 days?
☐ Yes / ☐ No
12. Have you received monoclonal antibody for SARS-CoV-2 (COVID) in the last 90 days?
☐ Yes / ☐ No
13. Vaccine Administration Consent: I request that the COVID-19 vaccination be given to me. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries. I agree to immediately report any significant adverse reaction to my primary care physician. I agree to continue safety practices such as wearing a face mask, social distancing, and frequent hand washing. I understand that protection against COVID-19 may not be effective until at least 14 days after the second dose. I agree to receive the second dose of COVID-19 vaccine in 28 days from the first dose. I understand the benefits and risks of the vaccination.

_____
Recipient (Signature)

_____
Print Name

_____
Date / Time