COVID-19 VACCINE SCREENING & CONSENT FORM - MODERNA

Last Name:_____ **First Name**:_____ **Middle Initial**:_____
Birth Date:_____ **Email Address**:_____
Month / Day / Year
Mailing Address:_____ **City**:_____ **State**:__NM____ **Zip**:_____
Daytime Phone:_____ Emergency Contact:_____**Relationship**:_____
First and Last Name

Gender: ☐ Male ☐ Female

Race: ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

INSURANCE INFORMATION – Fill the appropriate category – REQUIRED

Centennial Care/Medicaid: ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ Western Sky
Policy/ Member ID #_____ Centennial Care Medicaid #: _____Group #:_____
Medicare Part B:
Subscriber ID #_____ Responsible Party:_____ Policy Holder's Date of Birth: _____

☐ No Insurance ☐ Private Insurance

MEDICAL SCREENING QUESTIONS - REQUIRED

For patients: The following questions will help us determine if you should be given the vaccine today. If you answer "**yes**" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Please list: _____			
3. Have you ever had a serious reaction after receiving a vaccine, including a prior dose of COVID-19 vaccine?			
4. Do you have a bleeding disorder or are you taking a blood thinner? *If yes, be aware of possible bleeding/bruising.*			
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *If yes, first consulted with a provider (OBGYN or primary care)*			
6. For women: Are you nursing (breastfeeding) a child?			
7. Have you received any vaccinations in the past 14 days? I *If yes, re-schedule vaccination; recommended to receive no additional vaccines for 14 days.*			
8. Have you tested positive for COVID 19 in the last 10 days? *If yes, re-schedule vaccination for after isolation.*			
9. Have you received a COVID-19 vaccine in past? *If yes, be sure of timing and manufacturer for second dose.*			
10. Do you have an immune-suppressing condition or medicine? *If yes, be aware that vaccine effectiveness may be limited.*			

CONSENT FOR VACCINATION

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of Clovis Family Healthcare, to administer the vaccine I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine. I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the "Fact Sheet for Recipients and Caregivers" on the vaccine I have elected to receive. I also acknowledge that during vaccination I will have a chance to ask questions pertaining to my vaccination. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Clovis Family Healthcare, its staff, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parents) proof of immunization to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parents) is, a student or prospective student. I further authorize the applicable Provider to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Signature (Client/Guardian):_____ **Date:**_____

FOR CLINIC USE ONLY

Vaccine	NDC #	LOT #	Exp. Date	Site & Route
COVID-19 Moderna 1st Dose				
COVID-19 Moderna 2nd Dose				

Vaccinator (print name)	Signature:	Date of Service:
Title of Vaccinator:	VFC Pin#:	
Ordering Provider:	Date Entered in NMSIIS:	