Paradise Valley Medical Clinic

Douglas M. Lakin, MD

9977 N. 90th Street
Suite 180
Scottsdale, AZ 85258
(480) 614-5800
Fax (480) 614-6322

For vaccine recipients:

Patient Name ______________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ________			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
o Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ______________________ **Date** ______________

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Last Name: ______________________________ First Name: ____________________

Date of Birth (mm/dd/yyyy): __________________

Initials	Please initial in each box that you have read and understand the information below:
	I, the undersigned, have been provided a copy of the Vaccine Fact Sheet (FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER) that discusses the risks and benefits of the COVID -19 vaccine. I understand the benefits and risks, have been given the opportunity to ask questions with answers to my satisfaction and consent to administration of the vaccine.
	I understand that Moderna COVID-19 vaccine requires two (2) doses to confer immunity and if I do not receive both doses then I will not have full benefit from the vaccine. I understand that a second dose is subject to vaccine supply from the manufacturer. As with any vaccine, there is no certainty that I will become immune or that I will not experience any adverse side effects from the vaccine. I voluntarily assume full responsibility for any events that may result due to vaccination.
	I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand that I should report any adverse effects to both my provider and vaccine administrator.
	I understand that my employer or vaccine administrator is not responsible for my medical care and therefore I must discuss any medical concerns or care needs with my healthcare provider. I understand that if I experience any serious adverse reactions, I should call 911 or go to the nearest hospital. If I experience any adverse effects or have medical concerns, I should contact my healthcare provider. Even after immunization is complete, I will continue to follow all COVID-19 safety guidelines as required by my employer or recommended by the CDC and state/local health authorities.
	I authorize this information to be forwarded to the authorizing physician or local Department of Health, if applicable.
	I have answered all screening questions on the reverse side to the best of mv knowledge
	I consent to the administration of the COVID-19 vaccine.

On behalf of myself, my heirs, and my personal representatives, I hereby release PVMC that is administering the vaccine(s); the subsidiaries and affiliates of the organization from any and all liability that might arise from this vaccination.

Vaccine Recipient Signature: ______________________________ Date __________

VACCINE INFORMATION (Office Use Only)

Vaccine Name: Moderna COVID-19 Vaccine **Manufacturer: Moderna**

Date Of Administration:_______________

Dose: 0.5ml Route of Admin: Intramuscular Site Admin: Right Deltoid___Left Deltoid____

Vaccine Lot #____________________ **Exp. Date:**________________