

COVID-19 Immunization Screening Consent Form

Moderna Spikevax (Ages 12 & older)

Last Name	First Name	M.I.
Address	City	State Zip
Phone Number	Parent/Guardian Name (only if client is under age 18)	
Birth Date	Age	Sex Male Female

Please answer the following questions:

Circle One

Is the person to be vaccinated sick today?	YES	NO
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	YES	NO
Has the person to be vaccinated ever had a serious reaction to the Covid vaccine in the past?	YES	NO
Has the person to be vaccinated ever had Guillain-Barré Syndrome?	YES	NO
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	YES	NO
Is the person to be vaccinated anxious about getting a shot today?	YES	NO

By signing below, I acknowledge that I have read (or have had explained to me) the information regarding Covid-19 disease and the Covid-19 vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. Spikevax (Moderna) mRNA COVID-19 vaccine is FDA-licensed for use in ages 6 months through 64 years with at least one underlying condition that puts them at risk for severe COVID-19 infection and individuals 65 years and older. I understand the risk of the Covid-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request, and attest to factors that increase risk of severe Covid-19 infection for whom I am providing consent. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature also displays my understanding that I am responsible to provide payment of all charges at the time of service.

Patient Signature (or Guardian) _____ **Relationship to Patient** _____

Date Signed _____

For Office Use Only

INSURANCE			
Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Humana, Anthem, Amerihealth)			
Insurance Name: _____		Member ID: _____	
Primary / Secondary			
Private Insurance (ex: Anthem, MMO, UMR,)			
Insurance Name: _____		Member ID: _____	
Primary / Secondary		Insurance copied	Insurance on file
		Yes / No	Yes / No
		VIS Date	
		1/31/2025	
Medicare: Member ID _____		Staff initials	
Medicare Supplement:			
Insurance Name: _____		Member ID: _____ HMO / PPO	

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To be completed by nurse administering vaccine:

Date	Vaccine Name	Vaccine Lot #	Expiration Date	Manufacturer	IM Site	Dose	Staff initials
	Spikevax (12yrs &older)			Moderna	LD / RD	0.5 mL Pre-Filled Syringe	
Children 6 months-8 years ONLY : ☐ Initial Dose ☐ Second Dose ☐ Previously Vaccinated					LVL / RVL Temp: 		Circle One:
_____ I have reviewed the side effects with parent/guardian, as applicable. _____ I confirm that the patient/guardian was given the opportunity to ask questions about the vaccination, and all questions asked by them have been answered correctly, and to the best of my ability. _____ I have confirmed a VIS was offered and the patient has received a copy. _____ I have confirmed the consent is signed and dated. _____ I have reviewed the above questions and clarified any necessary information.							PRIVATE
							VFC
				Clinic Site:			