NORTHERN MONTANA HEALTH CARE

CONSENT FOR COVID – 19 VACCINATION
(MODERNA COVID – 19 VACCINATION)

Name (Last, First, Middle Initial)		**Date of Birth**		**Phone**
Address	**City**		**State**	**Zip**
Insurance Plan				

Before agreeing to receive the vaccine, please take time to answer the following questions:

1.	**ALLERGIES:** a. Do you have any ***SEVERE*** (life-threatening) allergies?	YES	NO
	b. Are you moderately or severely ill today?	YES	NO

This shot is a 2-shot series given with a time frame of at least 28 days separating doses.
Please read the Fact Sheet for recipients and caregivers for a list of possible side effects and the locations to report them.

I have read, or have had explained to me, the most recent Vaccine Information Statement (VIS) from the Centers for Disease Control (CDC) about COVID-19 and the COVID-19 Vaccination. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of COVID-19 vaccine and request the vaccine to be given to me or the person named below for whom I am authorized to make this request. I understand that this vaccination has been approved under the emergency use authorization program by the FDA.

____ ______________
Signature of person to receive vaccine or person authorized to make request Date

For Office Use Only	
Administer 0.5 ml of injectable COVID-19 vaccine intramuscularly (IM) (22-25g, 1-1½ “) in deltoid muscle Injection Site: ☐ LEFT DELTOID ☐ RIGHT DELTOID ____________________ ____/____/____ Nurse Signature Date	Manufacturer: ____________ Lot#: ________________ Exp. Date: _____________ VIS Date: __________

imMTrax Consent Form for Adults

Name:____ Sex: M___ F___ Date of Birth:___________

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Signature:____

Date:______________________________

Revised 10/2017 AD