COMMUNITY HEALTHCARE WORKER

COVID-19 Vaccination Form

Basic Information
Please enter your personal information below and provide answers to the vaccination questions.

**required fields*

Employer* _____ Title*_____

Date of Birth* _____/_____/_____

Legal First Name *_____ Gender* _____ Race*_____

Middle Name _____ Ethnicity*_____

Legal Last Name* _____

NPI (for Providers Only) _____

Contact Information
Please supply the best information to reach you for questions

Street Address* _____

City* _____ State* _____ Zip* _____

Primary Phone Number*_____ Mobile Phone Number _____

Email Address* _____ County*_____

COVID-19 Vaccination

☐ I consent to receive the COVID-19 Vaccination ☐ I decline to receive the COVID-19 Vaccination

☐ I already received the COVID-19 Vaccination

COMMUNITY HEALTHCARE WORKER

Contraindications

If you have any of the conditions below, it is recommended that you do not receive the COVID-19 vaccination without speaking to your healthcare provider

The manufacturer advises against administration of Moderna COVID-19 Vaccine to individuals with known history of a severe allergic reaction (e.g. anaphylaxis) to any component of the Moderna COVID-19 Vaccine. The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.

Do you have a history of an allergic reaction to any of these ingredients listed above? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to a vaccine? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to medicine or food? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Are you planning to become pregnant, pregnant or breastfeeding? *
☐ Yes ☐ No ☐ Prefer Not to Answer
If you are pregnant, please bring a physician note with permission to receive the vaccination.

Have you received any vaccine (pneumococcal, flu) within the last 14 days? *
☐ Yes ☐ No ☐ Prefer Not to Answer

For Nurses Only

Dose 1

3-4 ID of Vaccinator _____

3-4 ID of Triage _____

Lot # _____

Contraindications

Have any of these Contraindications changed since the participant consented?
☐ Yes ☐ No

Dose 2

3-4 ID of Vaccinator _____

3-4 ID of Triage _____

Lot # _____

Contraindications

Have any of these Contraindications changed Since the participant consented?
☐ Yes ☐ No

If yes, please identify what Contraindications changed

Dose 1

Do you have a history of an allergic reaction to any of these ingredients listed above? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to a vaccine? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to medicine or food? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Are you planning to become pregnant, pregnant or breastfeeding? *
☐ Yes ☐ No ☐ Prefer Not to Answer
If you are pregnant, please bring a physician note with permission to receive the vaccination.

Have you received any vaccine (pneumococcal, flu) within the last 14 days? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Does the participant qualify for the COVID-19 Vaccination? ☐ Yes ☐ No

Dose 2

Do you have a history of an allergic reaction to any of these ingredients listed above? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to a vaccine? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as an immediate-onset anaphylaxis to medicine or food? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Are you planning to become pregnant, pregnant or breastfeeding? *
☐ Yes ☐ No ☐ Prefer Not to Answer
If you are pregnant, please bring a physician note with permission to receive the vaccination.

Have you received any vaccine (pneumococcal, flu) within the last 14 days? *
☐ Yes ☐ No ☐ Prefer Not to Answer

Does the participant qualify for the COVID-19 Vaccination? ☐ Yes ☐ No

Participant Signature

I understand that the information completed on this form is correct to the best of my knowledge and that if a vaccine is administered, it may be required to share this information with state and/or federal jurisdictions. By checking this box, I hereby agree that the check mark serves as my electronic signature on this form. * ☐ Yes

Initials _____ Signature Date: _____/_____/_____