**Moderna COVID-19 VACCINE ADMINISTRATION RECORD**

I have been given a copy and read or have had explained to me the information in the Emergency Use Authorization (EAU) of the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 revised 12/2020. I understand the benefits and risks of the Moderna COVID-19 Vaccine and request that the immunization be given to me or the person named below for whom I am authorized to make this request.

I agree to remain at the vaccination site for 15 minutes following the immunization.

I also understand that the information collected on this form will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure continuation of health care services.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name (Last, First, Middle Initial) | | | Date of Birth | | **\* Age\*** | | | Male  Female | | |
| Maiden Name: | | Other last names you’ve had: | | | | | | | | |
| Telephone Number | | County | | | | | | | | |
| Address | | City | | State | | | Zip | | | |
| Ethnicity (check one)  Hispanic  Non-Hispanic | Race (check one) African American  Asian  Native American  White  Other | | | | | | | | | |
| Questions for person receiving vaccine: (Shaded column for Dose #2) | | | | | | Yes | | No | **Yes** | **No** |
| Are you sick today? | | | | | |  | |  |  |  |
| Have you had a severe allergic reaction to a previous vaccination? | | | | | |  | |  |  |  |
| Have you had a severe allergic reaction to any of the vaccine components? | | | | | |  | |  |  |  |
| Have you received a COVID-19 vaccine? If yes, date\_\_\_\_\_\_\_\_\_\_\_ Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | |  |  |  |
| Have you received passive antibody therapy for COVID-19 within the last 90 days? | | | | | |  | |  |  |  |
| Have you received any vaccine in the past 14 days? | | | | | |  | |  |  |  |
| \*Are you immunocompromised or on a medication that affects your immune system? | | | | | |  | |  |  |  |
| \*Are you pregnant or breastfeeding? | | | | | |  | |  |  |  |
| Signature of person to receive vaccine or authorized person:  X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Dose #1** Date | | **Dose #2** Date & Initial | | | | | |

------------------------------------------------**For Office Use Only**----------------------------------------------------------

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine** | **Site** | **Manufacturer** | **Lot Number** | **Exp. Date** | **Date Administered** |
| **Dose #1:** COVID-19 | RD LD | Moderna COVID-19 |  |  |  |
| **Dose #2:** COVID-19 | RD LD | Moderna COVID-19 |  |  |  |

**Signature and Title of Vaccine Administrator**: Dose #1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature and Title of Vaccine Administrator**: Dose #2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Created 1/4/2021