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COVID-19 Vaccination Form- Statement of Understanding, Permission & Assignment

Name:_____
(First) **(Last)**

Date of Birth: _____ **Drivers License:**_____

Circle Your Race: White Black American Indian/Alaskan Native Asian Other

Circle Your Ethnicity: Hispanic Non-Hispanic

Circle Your Sex: Female Male

County Of Residence:_____

Street Address: _____

City: _____ **State: NC** **Zip:**_____

Telephone Number: _____

E-mail address (if applicable): _____

Are you a frontline worker? Yes No
(healthcare, police, food processing, etc.)

Place of Employment:_____

Are you a part of a state or federal recognized tribal nation? Yes No
Name of tribe: _____

***How many conditions know to increase risk of severe illness from COVID-19 do you have?**

None One Two or More

*Moderate to severe asthma, cancer, cerebrovascular disease, chronic kidney disease, COPD, cystic fibrosis, heart conditions, high blood pressure, immunocompromised, liver disease, neurologic conditions, overweight or obesity, severe obesity, pregnancy, pulmonary fibrosis, sickle cell disease, smoking, thalassemia, diabetes

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INFORMED CONSENT FOR COVID-19 VACCINATIONS

1. CONSENT

I agree to voluntarily receive th **MODERNA COVID-19 VACCINE.**

I acknowledge that I have received and read the fact sheet regarding the vaccine, and that the risks and benefits of this treatment have been explained to me. I have been given the opportunity to ask questions regarding possible side effects and adverse outcomes.

I acknowledge that I have read this form in its entirety or it has been read to me, and I understand potential side effects and the risks and benefits of the vaccine. I accept the risks, rules, and regulations set forth. Knowing these and having had an opportunity to ask questions which have been answered to my satisfaction, I consent to being vaccinated.

2. INQUIRIES

Any questions about the use of, potential side effects and the risks and benefits of - **MODERNA COVID-19 VACCINE** are welcome. If you have any doubts or questions, please ask us for further explanation.

3. Use of Medical Records

The information that is obtained while you are receiving the vaccine will be treated as privileged and confidential. It is not to be released or revealed to any person except your physician without your written consent unless authorized in accordance with state and/or federal law. The information obtained, however, may be used for statistical analysis or scientific purposes with your right to privacy retained.

_____ _____

Signature of Patient or Legal Representative Date

_____

Date of Birth

_____

Print Name