COVID-19 VACCINE SCREENING AND CONSENT FORM
Moderna COVID-19 Vaccine

SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	First Name	Middle Initial	UTSA ID (abc123)

Date of Birth			Age in Years	Sex (Gender assigned at birth)
Month	Day	Year		☐ Male ☐ Female

Race
☐American Indian or Alaska Native ☐Native Hawaiian or Other ☐Other Asian ☐Other
☐Asian ☐Pacific Islander ☐Other Nonwhite
☐Black or African American ☐White ☐Other Pacific Islander

Ethnicity
☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

Address

City	State	Zip Code

Cell Phone Number

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose

SECTION 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question.	YES	NO
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past 90 days, have your received monoclonal antibodies or been diagnosed with COVID-19?		
8. Have you had, in the last 10 days, fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE

Please check YES or NO for each question.	YES	NO
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, please indicate which manufacturer's vaccine you received and date the dose was administered: ☐ Moderna COVID-19 vaccine Date administered: ☐ Pfizer-BioNTech COVID-19 vaccine ___________________________		
13. Did you experience a non-severe allergic reaction within 4 hours of a previous dose of COVID-19 vaccine? Non-severe allergic reactions can include: hives, swelling, redness, wheezing, GI symptoms, etc)? If yes, please explain:		