MILLINOCKET REGIONAL HOSPITAL
200 SOMERSET STREET
MILLINOCKET MAINE 04462

COVID-19 VACCINE CONSENT FORM

A. CLIENT INFORMATION– Please Print

Name: _____ DOB: _____

Address: _____ City/Town: _____ Zip: _____

Telephone Number: _____ Sex: M □ F □

B. HEALTH HISTORY

1. Do you have any of the following symptoms that could be due to Covid-19: Fever, chills, new cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea or vomiting, diarrhea: □YES □NO
   If yes, describe: _____
2. Do you have any allergies? □YES □NO
   If yes, describe: _____
3. Have you ever had a serious reaction or condition following any vaccine? □YES □NO
   If yes, describe: _____
4. Do you have any conditions that require regular visits to a doctor? □YES □NO
   If yes, please discuss with immunizer: _____
5. Is your immune system suppressed due to a disease/treatment/or autoimmune disorder? □YES □NO
   If yes, please discuss with immunizer: _____
6. Are you pregnant or breastfeeding? □YES □NO
   If yes, have you discussed the Covid-19 vaccine administration with your provider? □YES □NO
7. Have you received any vaccine in the last 14 day? □YES □NO
   If yes, what vaccine: _____
8. Are you taking any medication that affects blood clotting? □YES □NO
   If yes, please list: _____

C. **REASON FOR IMMUNIZATION**: Please check the first reason that applies (Check one box only)

1. □ Healthcare worker 2. □ High Risk 3. □ Contact of High Risk 4. □ No Known Risk

Healthcare workers only: Indicate your Primary Work Setting: _____

D. **INFORMED CONSENT**: I have read and understood the fact sheet(s) regarding the Covid-19 vaccine(s). I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction. I understand that I will be required to receive a second dose of this vaccine 28 days from the first dose. I consent that I will return for this second dose when required. I consent that my record of the Covid-19 Vaccine will be recorded in the Maine Immunization Registry. This registry allows my healthcare provider(s) to find out what immunizations I have had. This registry also may be used by my healthcare provider to produce an immunization record, identifying possible missed immunizations.

Date: _____ Signature: _____

THIS SECTION TO BE COMPLETED BY IMMUNIZATION STAFF

a. EUA Form Provided □ b.. Health History Completed and Reviewed □
c. Expected risks and benefits of Vaccine Provided □ d. V-safe Information provided □
e. Vaccine Record Card given to Client □

Vaccine: Moderna Covid-19 Vaccine **Lot #013L20A_____Expiration Date: 12/31/2069_____ Site**: L R Deltoid

Immunizer Signature: _____ Date: _____