Wayne Memorial Community Health Centers

COVID 19 VACCINE AUTHORIZATION 2020/2021

NAME: ____

Print-Last name/First name

Date of Birth: __________________

WMCHC along with the Center for Disease Control & Department of Health recommends persons aged > 18 years receive the COVID vaccination for the prevention of COVID-19, for their personal protection as well as for the protection of their families.

Are you currently ill or have a fever greater than 100.5? ☐ **Yes** ☐ **No**
Have you ever had an allergic reaction to any Vaccine or injectable medication? **Yes** **No**

Ethnicity: ____ Choose not to disclose Hispanic or Latino ____ Yes ____ No
Race: _____ Choose not to disclose
_____ Asian
_____Native Hawaiian
_____Other Pacific Islander
_____ Black/African American
_____ American Indian/Alaskan Native
_____ White/Caucasian
_____ More than one race

Vaccine: Moderna COVID -19 NDC # 80777-273-10

Route IM Site: RD LD Immunizer_____________________________________

MODERNA COVID-19 contains mRNA, Lipids(SM-102, 1,2-dimyristoyl-rac-glycero3-methoxypolyethylene glycol-2000[PEG2000-DMG], cholesterol, and 1,2-distearoyl-snglycero-3-phosphocholine [DSPC]), Tromethamine, Tromethamine hydrochloride, Acetic acid, Sodium acetate, and Sucrose.

COVID 19 VACCINES: This vaccine includes a short segment of messenger ribonucleic acid (mRNA). The mRNA is a genetic code that tells cells how to make a protein. It is intended to boost the immune system to produce enough antibodies against SARS-CoV-2; so, in case of an exposure, the virus does not cause illness.

I have reviewed the COVID Vaccine Statement provided and understand the benefits and risks of this vaccine. I **consent** for the COVID vaccine to be administered to me.

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to the above-named doctor(s). I also understand that I am fully responsible for payment of deductibles and co-insurance and any charges that are incurred and not covered by my health insurance.

Signature: ____ Date: ______________