Southern Coos Hospital and Health Center: CMS 381304 : 900 11th St., Bandon, OR 97411| Coos County

Moderna COVID-19 Vaccine Patient/Employee Acknowledgment Form

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone/Mobile Phone: _____ Email: _____
(This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

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

Vaccine Dose (check one): 1st ☐ 2nd ☐ If this is your second dose, what vaccine was your first? Pfizer ☐ Moderna ☐ Don't know ☐ If this is your second dose, when did you receive your first dose? (date): _____.

Exclusion Questions: Answering yes to either of these questions excludes you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine including lipids, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	☐ Yes	☐ No
Are you under the age of **18 years**?	☐ Yes	☐ No

Screening Questions: *Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes ☐	No ☐
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes ☐	No ☐
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes ☐	No ☐
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes ☐	No ☐
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes ☐	No ☐
Are you immune compromised or on a medicine that affects your immune system?	Yes ☐	No ☐
Do you have a bleeding disorder or are you on a blood thinner?	Yes ☐	No ☐
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes ☐	No ☐

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*

- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*

- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes*

- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*

- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*

- *I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of Southern Coos Hospital. I understand that it will keep records of this vaccination for me in Southern Coos employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature:* _____ Date: _____
By signing here I also attest that I fall within the vaccination category being provided today.

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

All sections below are for official use only:

Notes about this form:

- ***This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers*** https://www.fda.gov/media/144638/download**.**
- This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.
- This form is intended as a resource. It is not a mandatory form.
- This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. Organizations and individuals choosing to use this form should do so in consultation with their own clinicians and attorneys.
- This form is subject to update without notice. The most recent version of the form may be found on the WSHA website here: www.wsha.org/for-patients/coronavirus/coronavirus-resources-for-hospitals/
- For convenience, some elements in this form may be pre-recorded in electronic health records or other databases.
- Resources used in creating this form:
    - Fact Sheet for Health Care Providers Administering Vaccine: https://www.fda.gov/media/144637/download.
    - Fact Sheet for Vaccine Recipients and Caregivers https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-Clinical-Training-and-Resources-for-HCPs.pdf
    - V-Safe Program; https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
    - COVID-19 Vaccination Communication Toolkit: https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html
    - Washington State's COVID-19 Vaccine Plan for vaccine reporting requirements. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf
    - For Demographic Information:
        - Washington State CHARS Manual: https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf
        - Race Ethnicity Language Data Collection Best Practices: http://forces4quality.org/af4q/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf

    Collecting Sexual Orientation and Gender Identity Information: https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html

Last Name:	**First Name:**	**Mother's Maiden Name:**
Your Birthday:	**Department/Position:**	**Second Dose Date:**

VACCINE: 2020-2021 Moderna COVID-19 Vaccine

Signature First Dose:	**Signature Second Dose:**	**Employee** ☐ **Physician** ☐ **Volunteer** ☐

PLEASE SEE THE ADDITIONAL FORM FOR SCREENING QUESTIONS. COMMENTS:	**Dose # 1** **Lot #___037K20A_____** **Expiration Date__6/22/2021_____**
	Dose # 2, Booster Dose **Lot #__032L20A_____** **Expiration Date___04/18/2021____**

DO NOT WRITE BELOW THIS LINE (EMPLOYEE HEALTH NURSE SECTION ONLY)

Fifteen Minute Observation: ☐ Thirty Minute Observation: ☐	**Date First Vaccinated**:	**Date Second Dose Given:**
	Handouts Provided: UD Fact Sheet for Recipients ☐ V-Safe Sheet ☐	
Right Deltoid ☐ **#1 Dose** **Left Deltoid** ☐	**Nurse's Signature First Dose**:	**Nurse's Signature Second Dose:**
Right Deltoid ☐ **#2 Dose** **Left Deltoid** ☐		