WAYNE COUNTY HEALTH DEPARTMENT

MODERNA COVID-19 VACCINE ADMINISTRATION AND CONTRAINDICATIONS

Office Use Only:

Manufacturer: Moderna Primary Series NDC: 80777-0273-10 Bivalent Booster NDC: 80777-0280-05	**Moderna - 28 Day Dose Interval** **Minimum Age 12 - Doses 1, 2 or 3**	**Moderna Booster Dose Interval** **Min Age 18 - Moderna Bivalent Booster - 2 months after primary monovalent series or last booster dose**
	Lot #:	**Lot #:**
Site Given: RA LA RT LT	**Dosage is 0.5mL** *Circle Shot Dose:* **1st Ds 2nd Ds 3rd Ds**	**Dosage is 0.5mL** **Bivalent Booster: 1 Bstr Ds**
	CPT:91301 Admin: 0011A 0012A 0013A	**CPT: 91313 Admin: 0134A**

Insurance Information	**CLIENT STATES THEY DO NOT HAVE ANY INS COVERAGE**
Primary Insurance:	If Medicare coverage, make sure to ask for their primary insurance card or verify with them if they have a Medicare Advantage Plan in place of regular Medicare Part A & B coverage (red, white & blue card)
Secondary Insurance:	

*****ATTACH FRONT & BACK COPY of INSURANCE CARDS or MEDI PRINT OUT & SIGNED ATTESTATION for 3rd or BOOSTER DS*****

INFORMATION ABOUT PERSON TO RECEIVE COVID-19 VACCINE (PLEASE PRINT)

LEGAL NAME:	DATE OF BIRTH:	AGE:	SEX:
ADDRESS:	CITY:	STATE:	ZIP:
YOUR PHONE #	PRIMARY PHYSICIAN:		
EMERGENCY CONTACTS NAME:	EMERGENCY CONTACTS PHONE NUMBER:		
RACE: (Please Circle one) American Indian/Alaska Native, Asian, African-American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, White, Other Race or Unknown	ETHNICITY: (Please Circle one) Hispanic/Latino, Not Hispanic/Latino, Unknown		

Please Answer the Following Questions Below by Marking YES or NO

PLEASE NOTE: If you answer YES to any of these questions, please be advised that you may be informed that you should not receive the COVID-19 vaccine at this time and to contact your Primary Care Provider for further guidance and decision making on your next steps regarding getting vaccinated for COVID-19.

	COVID-19 SCREENING QUESTIONS	Yes	No
1	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?		
2	In the past two weeks, have you had contact with anyone who tested positive for COVID-19?		
3	Have you been experiencing any 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?		

	IMMUNIZATION SCREENING QUESTIONS	Yes	No
1	Have you ever had an anaphylaxis reaction to anything? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? **Anaphylaxis Reaction to:**_____		
2	Have you had a seizure, brain or other nervous system problem or Guillain-Barre Syndrome?		

(Continue on to other side for signature)

- I have been given and have had explained to me the information in the Vaccine Information Sheet/Emergency Use Authorization (EUA) regarding the Covid-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks regarding the Covid-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the Covid-19 vaccine given to me (or the person named above). **The person receiving this vaccine is in good health at this time and is not known to have any medical issues that may result in severe allergic reaction to this vaccine.** I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of Guillain-Barre syndrome, have a known anaphylaxis allergy, or have experienced severe problems after getting a vaccination.
- I will not hold Wayne County Health Department or the individual giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid or Insurance claim for administration of the vaccine if applicable. I request payment of benefits to Wayne County Health Department. *NOTE TO CLIENTS: WCHD will only bill your insurance for the administration of the vaccine. You will not be billed or have to pay for anything related to this vaccination regardless if you have active insurance coverage or not.*
- I give the Wayne County Health Department permission to release said Covid-19 information to any requesting Physician/Medical Facility/School/Employer should said request be made.
- I understand that my Covid-19 vaccination information will be entered in the State of Illinois Registry known as I-Care as is required for all vaccines given by Wayne County Health Department.

I have read and understand the above information, and have had the opportunity to ask any questions concerning the vaccine.

Signature if age 18 & up
or Parent/Legal Guardian:_____ Date:_____

Nurse providing the
Immunizations: _____ Date:_____

Please note: The CDC recommends that you wait a minimum of 15 minutes after receiving any immunizations.

Depending on your answers above, you may be asked to wait for 30 minutes after receiving said vaccine.

If you experience any problems, please notify a staff member immediately.