BROWARD COMMUNITY & FAMILY HEALTH CENTERS, INC.
COVID-19 VACCINE SCRENING AND CONSENT FORM
Moderna COVID-19 Vaccine

Section 1: INFORMATION ABOUT YOU (PLEASE PRINT)

Last Name	**First Name**	**Middle Name**
DATE OF BIRTH Month DAY YEAR	**Age in Years:**	**Sex (Gender assigned at birth)** □ Male □Female
Race □ American Indian or Alaska Native □ Native Hawaiian or Other □ Other Asian □ Asian □ Pacific Islander □ Other □ Black or African American □ White		**Ethnicity** □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown
Address		
City	**State**	**Zip Code**
Cell Phone	**Home Phone**	

Primary Insurance Carrier ID#		**Group#**	
Insurance Company		**Insurance Company Phone #**	
Insured Name		**Relationship**	**Insured Date of Birth:**

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 ingredient of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment or 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 vaccination in the previous 14 days?		
7. In the past two weeks, have you tested positive for 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?		

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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 reaction to any medication, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune systems?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a pervious dose of any COVID-19 vaccine? If yes, which manufacture's vaccine did you receive?		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 16 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the COVID-19 vaccine.

- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the Broward Community & Family Health Centers, Inc. (BCFHC), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) BCFHC will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

- I further authorize BCFHC or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to BCFHC or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if BCFHC invoices me after the time of service, upon receipt of such invoice.

- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: _____Date: _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

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Site (LD/RD)	Route	Manufacture (MVX)	Lot # Unit of Use	Expiration Date	Date of EUA Fact Sheet
	IM				

Administered at Location (Facility Name/ ID):	
Administered at Location (Type);	
Administration Address:	
CVX (Product):	
Sending Organization:	

Vaccinator (Print Name)		**Signature**		**Date**	
Vaccine Administering Provide Suffix:					