



York Hospital  
 15 Hospital Drive, York ME 03909  
 207-363-4321

Patient Label

**Moderna COVID-19 Vaccine Consent**

Patient Name (*please print legibly*): \_\_\_\_\_

York Hospital Staff Member?  Yes  No

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of PCP: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_

**Please answer the following questions:**

1. Have you received plasma or MAB in the past 90 days? (vaccine can now be given >90 days after receipt of either product)  Yes  No
2. Have you received convalescent plasma or monoclonal antibody therapy as treatment for COVID-19?  Yes  No
3. Do you have a history of a severe allergic reaction to anything?  Yes  No
4. Have you had a previous COVID-19 vaccine?  Yes  No
5. Have you received any vaccines in the last 14 days?  Yes  No

**PATIENT CONSENT:**

I have been provided with a **EUA** sheet for COVID-19. I have had the opportunity to ask questions which have been answered to my satisfaction. I believe that I understand the risks and the benefits of the vaccine and request that it be administered to me.

\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Date

**VACCINE ADMINISTRATION:**

- 1) Injection Site: Deltoid  Left  Right Vaccine Lot # \_\_\_\_\_  
 Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Vaccine Given By: \_\_\_\_\_  
 1<sup>st</sup> Dose  2<sup>nd</sup> Dose Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_



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