COVID-19 Vaccine Registration Form – **Moderna**

First Name	M.I.	Last Name	Sex
			☐ Female (F) ☐ Male (M) ☐ Other (O) ☐ Unknown (U)

Date of Birth	Age	17 or Under?	SSN
		☐ Yes ☐ No	

Phone Number	
	☐ Resident ☐ Healthcare Worker/Staff ☐ Other

Street Address	City	State	Zip

RACE
- ☐ Alaskan Native (5) *1002-5*
- ☐ American Indian (5) *1002-5*
- ☐ Asian (4) *2028-9*
- ☐ Black (2) *2054-5*
- ☐ Native Hawaiian (7) *2076-8*
- ☐ Pacific Islander (7) *2076-8*
- ☐ White (1) *2106-3*
- ☐ Other (6) *2131-1*
- ☐ Unknown (9)*UNK*

ETHNICITY
- ☐ Hispanic/Latino (1) *2135-2*
- ☐ Not Hispanic/Latino (2) *2186-5*
- ☐ Unknown (3) *UNK*

Patient Questions – Answer the Day of Vaccination

Do you feel sick today?	☐ No	☐ Yes
Have you ever had a severe allergic reaction to a vaccine, medication, food, or latex in the past?	☐ No	☐ Yes
Have you had COVID-19 in the last two weeks?	☐ No	☐ Yes
Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No	☐ Yes *
Have you had a history of myocarditis or pericarditis after a dose of Moderna or Pfizer COVID-19 vaccine?	☐ No	☐ Yes
Do you have any serious health conditions (often called co-morbidities)? (diabetes, obesity, lung disease)	☐ No	☐ Yes *
Do you have a weakened immune system (ie, from HIV or cancer or are you on immunosuppressive drugs?)	☐ No	☐ Yes
Are you pregnant, planning to become pregnant in the next month, or breastfeeding?	☐ No	☐ Yes
Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐ No	☐ Yes

What group are you in? (select only one)
- ☐ Resident in a LTC Facility
- ☐ Resident in an Assisted Living Facility
- ☐ Resident in a Congregate Care Facility
- ☐ Healthcare worker 18-64 years old
- ☐ Occupational exposure to COVID-19 18-64 years old
- ☐ 65 years and older
- ☐ 18-64 years of age with underlying medical condition(s)

Underlying medical conditions include: cancer, chronic kidney disease, chronic lung diseases (including COPD/chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis, and pulmonary hypertension), dementia or other neurological conditions, diabetes (type 1 or type 2), Down syndrome, heart conditions (such as heart failure, coronary artery disease, cardiomyopathies or hypertension), HIV infection, immunocompromised state (weakened immune system), liver disease, overweight and obesity, pregnancy, sickle cell disease or thalassemia, smoking (current or former), solid organ or blood stem cell transplant, stroke or cerebrovascular disease, or substance use disorders

Additional Dose COVID-19 Vaccination **Facility Vaccinator MUST COMPLETE**

Vaccine Name	Lot Number	Expiration Date	Site of Injection
COVID-19			☐ Right Deltoid (RD) ☐ Left Deltoid (LD)

Route of Admin	Primary Series (0.5ml):	Booster Dose (0.25ml):	Date of Vaccination (mm/dd/yyyy)
☒ IM	☐ Moderna 1st dose (0.5ml)	☐ Moderna 1st booster (0.25ml)	
	☐ Moderna 2nd dose (0.5ml)	☐ Moderna 2nd booster (0.25ml)	
	☐ Immunocompromised Only - Moderna 3rd dose (0.5ml)		

Vaccinator Name (Print)	Vaccinator Signature	Facility Name

ICP, Inc. Use

☐ State ISS Entry ☐ Federal CVRS Entry