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

First Name	M.I.	Last Name	Sex	**RACE**
			☐ Female (F) ☐ Male (M) ☐ Other (O) ☐ Unknown (U)	☐ Alaskan Native *1002-5* ☐ American Indian *1002-5* ☐ Asian *2028-9* ☐ Black *2054-5* ☐ Native Hawaiian *2076-8* ☐ Pacific Islander *2076-8* ☐ White *2106-3* ☐ Other *2131-1* ☐ Unknown *UNK*
Date of Birth		SSN		
COVID Vaccine Dose #	Phone Number	☐ Resident ☐ Healthcare Worker/Staff ☐ Other		**ETHNICITY** ☐ Hispanic/Latino *2135-2* ☐ Not Hispanic/Latino *2186-5* ☐ Unknown *UNK*
Street Address	City	State	Zip	

Patient Questions – Answer the Day of Vaccination

1.	Do you feel sick today?	☐ No	☐ Yes
2.	Have you ever had a severe allergic reaction to a vaccine, medication, food, or latex in the past?	☐ No	☐ Yes
3.	Have you had COVID-19 in the last two weeks?	☐ No	☐ Yes
4.	Have you had a history of myocarditis or pericarditis after a dose of Moderna or Pfizer COVID-19 vaccine?	☐ No	☐ Yes
5.	Do you have a weakened immune system (ie, from HIV or cancer or are you on immunosuppressive drugs?)	☐ No	☐ Yes
6.	Are you pregnant, planning to become pregnant in the next month, or breastfeeding?	☐ No	☐ Yes
7.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐ No	☐ Yes
If "Yes" for question 1-7, consult with prescriber before proceeding.			
8.	Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?	☐ No	☐ Yes *
9.	Do you have any serious health conditions (often called co-morbidities)? (eg. diabetes, obesity, heart, or lung disease)	☐ No	☐ Yes *

Facility Vaccinator MUST COMPLETE

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

(Bi-Valent Moderna)
NDC 80777-282-05
Dark Blue Cap – Gray Label Border

☐ Primary Dose (0.5ml)
Previously unvaccinated

☐ 1st Bi-Valent Booster Dose (0.5ml)

☐ 65 & Older Only
2nd Bi-Valent Booster Dose (0.5ml)

☐ Immunocompromised
2nd Bi-Valent Booster Dose (0.5ml)

Date of Vaccination (mm/dd/yyyy)

Time of Vaccination

Vaccinator Name (Print)	Vaccinator Signature	Facility Name

ICP, Inc. Use

☐ State ISS Entry ☐ Federal CVRS Entry