COVID-19
Vaccine Screening and Agreement

Rice County Public Health
320 NW Third Street; Suite 1
Faribault, MN 55021
507-332-6111

Last Name (*please print*)	**First Name**	**Middle Initial**	**Birth Date** *(mo/day/year)*	**Age**

Street Address	**Phone**	**Male** ☐	**Female** ☐

City	**State**	**Zip Code**	**Mother's Name (last, first, middle - if younger than 18 years):**

Information collected on this form will be used to document that you have received vaccine(s). Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you have questions about MIIC, refer to MIIC and the Public (www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

***Assignment of benefits and responsibilities for payment**: This allows us to bill your health plan or company and receive payment directly. There is no cost for the COVID-19 vaccine, although you may be billed an administration fee.*

I authorize this health provider to bill my health plan or other payers on my behalf, and to receive payment of authorized benefits.

PAYMENT INFORMATION

☐ Check here if person receiving the vaccine does not have insurance.

Medicare ID# _____

Insurance

1. _____
Name of Private Insurance

_____
ID#

2. _____
MA or PMAP (UCare, Blue Plus, Medica)

_____
ID#

HEALTH HISTORY

Check an answer for each question, and talk to your health care provider prior to vaccination if you answer yes to any of the following:

Yes	No	Question
Yes ☐	*No* ☐	Severe allergic reaction (e.g., anaphylaxis) to a previous dose of COVID-19 vaccine? (If yes, you should not receive vaccine)
Yes ☐	*No* ☐	History of severe allergic reaction (e.g., anaphylaxis) to a component of the COVID-19 vaccine? (If yes, you should not receive vaccine)
Yes ☐	*No* ☐	History of severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular (in the muscle), intravenous (in the vein), or subcutaneous (under the skin))? (If yes, recommended observation x30 minutes post vaccination)
Yes ☐	*No* ☐	Currently ill due to COVID-19? (Vaccines should be delayed until improvement of illness)
Yes ☐	*No* ☐	Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? (If yes, delay vaccination x90 days)
Yes ☐	*No* ☐	Exposed to another person with known COVID-19 disease? (If yes, defer until quarantine ended)
Yes ☐	*No* ☐	Have you received a previous dose of COVID-19 vaccine? (If yes, need to receive the same product)
Yes ☐	*No* ☐	Are you pregnant? (If yes, can vaccinate if individual has discussed risk/benefit with primary medical provider and is part of a group considered at risk of exposure (e.g. healthcare personnel)
Yes ☐	*No* ☐	Received another non-COVID vaccine in the last 14 days? (If yes, reschedule COVID vaccination at least 14 days from non-COVID vaccination date)

AGREEMENT: I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the Moderna COVID-19 Vaccine. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.

Signature of patient or parent/guardian: X_____ Date: _____

FOR CLINIC USE ONLY - Please do not write below.

COVID-19 Vaccine Presentation	EUA Fact Sheet Date	Dose	Route	Manufacturer	Lot Number	Admin Site - Circle
COVID-19 (Moderna)	12/2020	0.50 cc	IM	MOD		LD / RD

Signature and title of person administering vaccine:_____ Date administered:_____