



COVID-19 VACCINE CONSENT FORM

NAME: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____, NJ ZIP CODE: _____

PHONE NUMBER: _____ HOME OR CELL

RACE: _____ ETHNICITY: _____

PLACE OF BIRTH: _____ SINGLE OR MULTIPLE BIRTH

1. Have you completed your Pre-Vaccination Checklist? YES NO

Reviewed by Nurse: _____

Comments:

I have read, or have had explained to me, the CDC Emergency Use Authorization Form about the Moderna Vaccine. I acknowledge that I have been given the opportunity to review the PHCTR Notice of Privacy Practices on this date. I understand that this vaccine may cause symptoms in some people but will not actually cause the Covid Virus. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Covid vaccine and request that the vaccine be given to me or for whom I am authorized to make this request. I have answered all questions truthfully and accurately.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Name of Vaccine : _____ Dose number : _____

Manufacturer: _____

Lot number : _____ Expiration date: _____ LEFT RIGHT DELTOID

Administered by _____ Date _____