**COVID-19 Vaccine**

**Administration Consent**

**Vaccine Recipient Information**

Recipient Name:

 Last First M.I.

Address:

 Street City State Postal Code

Date of Birth: Age: Gender: [ ]  Male [ ]  Female

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Healthcare Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature: Date:

**Healthcare Provider Use Only**

Date Vaccine Administered: Injection Site (Deltoid): [ ]  Left [ ]  Right

Manufacturer: Moderna\_\_\_\_\_\_\_\_\_\_\_\_\_ Lot Number: Exp:

Administered by Print: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  COVID-19 Vaccine EUA FACT SHEET for Recipients provided