Skin Esteem LLC

431 Country Club Way
Kingston, MA. 02364
781-422-3811

Moderna COVID-19 Vaccine Screening and Consent Form

Section 1: Information about Person to Receive Vaccine (Please print)

NAME (First)	(Last)	(M.I.)	Male / Female	DOB: / /

Section 2: Screening for COVID-19 Vaccine Eligibility

Please circle YES or NO for each question

Are you under 18 years of age?	**YES**	**NO**
Have you received any vaccinations within the last 14 days?	**YES**	**NO**
Have you ever had a severe allergic reaction following a previous dose of COVID-19 vaccine?	**YES**	**NO or NA**
Do you have a known allergy to an ingredient of the COVID-19 vaccine? This includes polyethylene glycol (PEG) and Polysorbate.	**YES**	**NO**
Do you have an immediate allergic reaction of any severity to polysorbate?	**YES**	**NO**
Are you currently pregnant or plan to become pregnant and *have not* discussed receiving the vaccine with your OB/GYN Provider?	**YES**	**NO or NA**
Do you have any symptoms of COVID-19? This includes fever greater than 100F in last 24 hours, diarrhea, diagnosis with any contagious medical conditions in last 14 days, and shortness of breath.	**YES**	**NO**
Have you received monoclonal antibody treatment for COVID-19 ≤90 days ago?	**YES**	**NO**

IF ANY QUESTION LISTED ABOVE IS ANSWERED YES, THE INDIVIDUAL IS NOT A CANDIDATE TO RECEIVE COVID-19 VACCINE

Do you have a history of anaphylactic allergic reaction to a vaccine or injectable medication?	**YES**	**NO**

Section 3: VACCINATION INFORMATION and CONSENT FOR VACCINE

I, the undersigned, hereby authorize Skin Esteem, LLC, its employees, and agents, to treat me with the Moderna vaccine. I have read or have been provided with a fact sheet explaining what to expect after receiving the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination. I voluntarily consent to administration of the COVID-19 vaccine and assume the risk for any reactions that may result. **I agree to stay in the building for 15 minutes (30 minutes if I have a history of an anaphylactic allergic reaction to any vaccine or injectable medication.** I understand I may experience soreness or swelling at the injection site, fever or generally not feel well for 24-48 hours. If symptoms become severe, I will contact my primary care provider or seek emergency care.

I, for myself and my heirs, personal representatives, successors and assigns, hereby release Skin Esteem, LLC, its employees, and agents, from any claims or liabilities that I may have, now or in the future, known or unknown, of any nature whatsoever, arising from or related to my treatment.

I certify that I have read this entire document and that I agree with all provisions.

Date: _____ Print Name: _____

Time: _____ Sign Name: _____

Section 4: *** ADMINISTRATIVE USE ***

Vaccine (Circle Dose)	Route	Site	Date Dose Administered	Vaccine trade name/ Manufacturer	Lot Number	Expiration Date	Name & Title of Vaccine Administrator
COVID-19 0.5ml	**IM**	R-Deltoid L-Deltoid	/ /	Moderna COVID-19 Vaccine			