NAU NORTHERN ARIZONA UNIVERSITY

Campus Health Services

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nau.edu/campus-health-services

COVID 19 Dose #2 Consent Form 2021

Patient Name: **NAU ID:** **DOB:**

MEDICAL HISTORY	YES	NO	Don't Know
Are you currently ill and/or experiencing COVID-19 like symptoms such as cough, fever, chills or shortness of breath, or are you currently under quarantine for direct exposure to someone who tested positive for COVID-19?	☐	☐	☐
Do you have severe allergies (i.e. anaphylaxis) to **medications, food, a vaccine component, or latex**? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? *If yes, you will be asked to stay for **30** minutes after vaccination.*	☐	☐	☐
Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving **a vaccine or injectable medication**? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? *If yes, you will be asked to stay for **30** minutes after vaccination.*	☐	☐	☐
Do you have any medical condition that has compromised your immune system? *If yes, be aware there are no studies on the safety or effectiveness of this vaccine in this population.*	☐	☐	☐
Do you have a bleeding disorder or are you currently taking a blood thinner medication? *If yes, you will need to hold firm pressure to the vaccination site for 2 minutes after vaccination.*	☐	☐	☐
Have you received any vaccine in the last 14 days? *If yes, please reschedule appt for after 14 days.*	☐	☐	☐
Are you pregnant or breastfeeding? *If yes, be aware there are no studies on the safety or effectiveness of this vaccine in this population, consider talking with your OB/GYNE/PCP first.*	☐	☐	☐
Have you ever had a positive test for COVID-19 or has a provider ever told you that you had COVID-19? *If yes, we recommend you wait 30 days after your positive test before getting vaccinated.*	☐	☐	☐
Have you received passive antibody therapy as treatment for COVID-19? *If yes, vaccination should be deferred for 90 days after antibody therapy.*	☐	☐	☐

I have read or received the Covid-19 vaccine Fact Sheet and had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risk of the COVID-19 vaccine and request to receive the vaccine today. I agree to have Northern Arizona University Campus Health Services release my information about this vaccination to the Arizona State Immunization Information System (ASIIS), other health care providers upon request, and the minimum necessary information essential to administrative processing in the management of the Covid outbreak. When insurance is billed, I hereby authorize NAU CHS to furnish information to insurance carriers concerning my visit, and I assign payments for medical services rendered to NAU CHS.

Patient/Guardian Signature **Date**

---------- **FOR STAFF USE ONLY**----------

VACCINE	MGF	LOT #	Expiration date	SITE	ROUTE	DOSE
Moderna COVID-19 Vaccine	Moderna			RD LD	IM	0.5 mL

Notes:_____

Vaccinator Signature_____ Date administered, and Fact Sheet given _____/_____/_____

Vaccination time: _____