

COVID-19 Moderna Vaccine Survey PDF1

COVID-19 Vaccine Survey

Please be advised, the Nutley Health Department COVID-19 vaccination clinic is for Individuals that live and/or work in Nutley and are 18+ years of age.

Please answer every question for registration to be processed.

Patient Last Name: _____ Patient First Name: _____

Street Address: _____ Apt#: _____

Township: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Patient Date of Birth: __/__/____ Sex: Male/Female

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Race:

- African American/Black
- Asian
- American Indian/Alaska Native
- Native Hawaiian or other Pacific Islander
- White
- Refused
- Other

Ethnicity:

- Hispanic/Latino
- Non-Hispanic/Latino
- Unknown

****Please answer the following questions by typing YES or NO****

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A. Important Information

- I give consent to release my vaccination records to the Essex County Health Department.
- I give consent to release my vaccination records to the State Of New Jersey Immunization Information System.
- I consent to be vaccinated.

- I have read the [Moderna Emergency Use Authorization \(EUA\)](#) document
- I have read the FDA overview of the [Moderna COVID-19 Vaccine](#)

YOUR RESPONSE: I AGREE _____ *(please answer here yes or no)*

B. Current COVID-19 Symptom Assessment:

Do you currently have any of the following symptoms?

- Congestion or runny nose
- Cough
- Diarrhea
- Fatigue
- Fever or chills
- Headache
- Muscle or body aches
- Nausea or vomiting
- New loss of taste or smell
- Shortness of breath or difficulty breathing
- Sore throat
- Have you or anyone you have been in close contact with been diagnosed with COVID-19, or have been placed on quarantine for possible contact with COVID-19?
- Have you been asked to self-isolate or quarantine by a healthcare professional or a local health official?

YOUR RESPONSE: _____ *(please answer here yes or no)*

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C. Contraindications to receiving the COVID-19 Vaccine

Please review the below and answer "YES" if any of these statements are true:

You have received ANY vaccine in the last fourteen days.

You have ever received a COVID-19 vaccine.

You have ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital.

You have received passive antibody therapy as treatment for COVID-19?

You are pregnant or breastfeeding?

You are on Immunosuppressive drugs?

Do you have a bleeding disorder or are you taking a blood thinner?

Do you have known allergies to Polyethylene Glycol (PEG), which is found in some medications such as laxative and preparations for colonoscopy procedures?

Do you have known allergies to Plysorbate, which is found in some vaccines, film coated tablets and intravenous steroids?

YOUR RESPONSE: _____(please answer here yes or no)

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Nutley Department of Health (DOH) or its agents to administer the COVID-19 vaccine.

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. I acknowledge if I have a history of any anaphylaxis, I must remain near the vaccination location for approximately 30 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

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On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of New Jersey, the Township of Nutley Health (DOH), the Nutley Division of Emergency Management (OEM), Nutley Volunteer Emergency and Rescue Squad (NVERS) and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that: (a) I understand the purposes/benefits of New Jersey Immunization Information System (NJIIS), immunization registry and (b) DOH will include my personal immunization information in NJIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

I further authorize Nutley Health Department, or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Nutley Health Department, or its agents with respect to the above requested items and services.

D. Insurance Information:

- Insurance Provider/Carrier Name: _____
- Provider Member ID #: _____
- Group ID #: _____

*There is no out of pocket expense for vaccine to residents.

*Uninsured residents will not be denied vaccine or billed for vaccine

All Questions Must Be Answered to Process Registration!