Moderna COVID-19 Vaccine Consent Form

The Not-for-Profit Hospital Corporation, commonly known as the United Medical Center has provided me the opportunity to be vaccinated with the COVID-19 Vaccine. I have chosen to accept the COVID-19 Vaccine.

I have been informed, and I understand, that NOT receiving the Moderna COVID- 19 Vaccine (the "COVID-19 Vaccine") may place me at greater risk for getting the Coronavirus Disease 2019 (COVID-19).

In addition, I acknowledge that the United Medical Center provided me with a copy of the Fact Sheet for Recipients dated December 2020. I have had the opportunity to review the Fact Sheet, and I affirm that I understand its contents, including the benefits and the risks of the COVID-19 Vaccine. I understand who should and who should not be vaccinated, and what I might experience including possible side-effects from the vaccination.

Allergy: ____

Received a vaccine in the past: Yes __ No __ Temperature _______

Manufacture	Vaccine Lot #	Expiration Date	Injection Site	Staff giving the Vaccine

Date: _____________

ID Badge# ________ Department ________________

Name (Print) ____

Signature ____

Address: ____

Mobile #: _____________________