



Moderna SPIKEVAX® COVID-19 Vaccine Consent Form

Please fill in or put label: Last Name, First Name, Community, DOB

Please ensure name, community, and date of birth are completed above.

Health card number (if known): House number (optional):

Phone number: Email address (optional):

Gender: Man o Woman o Prefer to self-describe o Age:

For the person receiving the vaccine, please answer:

Is this your first or second dose... 1. Do you feel sick with a fever today? 2. Have you had COVID-19? 3. Are you, or could you be pregnant? 4. If this is your second or third dose, did you have any side effects after previous doses? 5. Do you have any problems with your immune system... 6. Do you have a bleeding disorder... 7. Have you had a serious reaction to a vaccine... 8. Are you allergic to polyethylene glycol... 9. Have you ever had a severe allergic reaction... 10. Have you ever been diagnosed with myocarditis...

* Breastfeeding is not a contraindication... ** Polyethylene glycol (PEG) can rarely cause allergic reactions... *** Tromethamine can rarely cause allergic reactions... **** Very rare cases of myocarditis and pericarditis following vaccination...



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 Department of Health
 Munaqhiijiyitkut
 Ministère de la Santé

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Please fill in or put label:

Last Name _____
 First Name _____
 Community _____
 DOB (dd/Month/yyyy) _____

For Administrative Use Only:

	DOSE	LOT#	SITE & ROUTE	GIVEN BY & WHEN Name and designation/Date and time
1st Dose	0.5 ml			Name:
				Date: <u>dd /Month / yyyy</u> Time:
2nd Dose	0.5 ml			Name:
				Date: <u>dd /Month / yyyy</u> Time:
3rd Dose	0.5 ml			Name:
				Date: <u>dd /Month / yyyy</u> Time:

Comments: