

# CLINICAL PROCEDURE

## EMS COVID19 VACCINE ADMINISTRATION

### Moderna mRNA cx-024414

COVID19 VACCINATION MODERNA mRNA cx-024414 PROCEDURE

Indication	Dose Regimen
FDA Emergency Use Authorization for active immunization of individuals 18 years of age and older to prevent COVID-19 caused by SARS-CoV-2 virus	<div style="display: flex; align-items: center; justify-content: center;"> <div style="text-align: center; margin-right: 10px;"> <h1 style="font-size: 2em; color: orange;">2</h1> <h2 style="color: orange;">DOSES</h2> <p style="background-color: blue; color: white; padding: 2px;">ONE MONTH APART</p> </div> <div style="border: 1px solid black; background-color: yellow; padding: 5px; text-align: center;"> <p><b>Must both be Moderna</b></p> </div> </div>

Cautions
<ul style="list-style-type: none"> <li>History of severe allergies or reactions to any medications, foods, vaccines, or latex → Monitor closely after administration (minimum 30 minutes)</li> <li>Immunocompromised or on a medication that affects the immune system → Inform patient vaccine might not provide as strong an immune protection</li> <li>Bleeding disorder or taking blood thinners → Risk of hematoma at injection site</li> <li>Received first dose of another COVID-19 Vaccine → Ensure same manufacturer as previous dose</li> </ul>

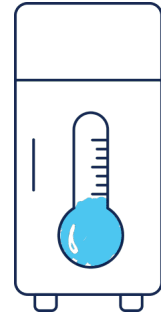
Contraindications															
<ul style="list-style-type: none"> <li>Known history of a severe allergic reaction (e.g. anaphylaxis) to any component of the Moderna COVID-19 vaccine</li> <li>Age less than 18 years old</li> <li>Current Illness (infection)</li> <li>Received any type of vaccination in the last 14 days</li> <li>Currently pregnant, breastfeeding or chance of becoming pregnant → Refer patient to their Primary Care Physician</li> <li>Any of the following symptoms in the last 10 days:               <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">○ Fever (&gt;100.4F)</td> <td style="width: 33%;">○ Chills</td> <td style="width: 33%;">○ Cough</td> </tr> <tr> <td>○ Shortness of Breath</td> <td>○ Difficulty Breathing</td> <td>○ Fatigue</td> </tr> <tr> <td>○ Muscle or Body Aches</td> <td>○ Headache</td> <td>○ Diarrhea</td> </tr> <tr> <td>○ Sore Throat</td> <td>○ Congestion or Runny Nose</td> <td>○ Nausea</td> </tr> <tr> <td>○ Vomiting</td> <td>○ New Altered Sense of Taste or Smell</td> <td></td> </tr> </table> </li> </ul>	○ Fever (>100.4F)	○ Chills	○ Cough	○ Shortness of Breath	○ Difficulty Breathing	○ Fatigue	○ Muscle or Body Aches	○ Headache	○ Diarrhea	○ Sore Throat	○ Congestion or Runny Nose	○ Nausea	○ Vomiting	○ New Altered Sense of Taste or Smell	
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Complications
<ul style="list-style-type: none"> <li>Allergic/anaphylactic Reaction</li> <li>Bleeding, local site pain, infection</li> <li>Common side effects (fever, headache, chills, muscle aches, fatigue)</li> </ul>

Patient Preparation
<ul style="list-style-type: none"> <li>Ensure appropriate monitoring equipment and treatment supplies are available to manage any adverse reactions (e.g. anaphylaxis)</li> <li>Verify correct patient identification</li> <li>Confirm “Covid-19 Screening and Consent Form” has been completed</li> <li>Ensure “Notice of Privacy Practices” and “EUA Fact Sheet for Recipients and Caregivers” have been provided</li> <li>Re-confirm patient meets indications and has no contraindications</li> </ul>

**Vaccine - Storage and Handling**

- Multiple-dose vials are stored frozen between -25° to -15°C (-13° to 5°F).
- Store in the original carton to protect from light. Do not store on dry ice or below -40°C (-40°F).
- May be stored refrigerated between 2° to 8°C (36° to 46°F) for up to 30 days prior to first use. **DO NOT re-freeze once thawed.**
- Unpunctured vials may be stored between 8° to 25°C (46° to 77°F) for up to 12 hours. **DO NOT refreeze.**



**Vaccine - Dose Preparation**

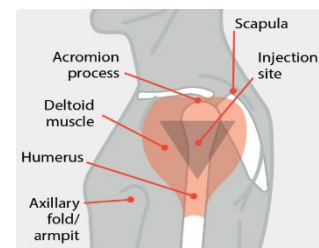
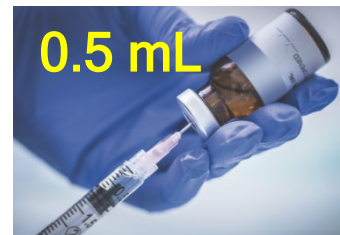
1. Each patient dose is 0.5 mL
2. There are 10 doses per vial – **DO NOT dilute the vaccine**  
 \*\*\*Note - A vial may contain more than 10 doses due to manufacturing – Utilize all **FULL DOSES** from a vial but **DO NOT** mix partial doses from multiple vials\*\*\*
3. The Moderna COVID 19 vaccine is a white to off-white suspension.
  - It may contain white or translucent product related particulates.
  - Visually inspect the Moderna COVID 19 vaccine vials for other particulate matter and/or discoloration prior to administration.
    - If either of these conditions exists, the vaccine should not be administered.
4. Remove the required number of vials from frozen storage and thaw each vial before use:
  - Thaw in refrigerated conditions between 2° to 8°C (36° to 46°F) for 2 hours and 30 minutes. After thawing, let vial stand at room temperature for 15 minutes before administering.
  - Alternatively, thaw at room temperature between 15° to 25°C (59° to 77°F) for 1 hour.
  - After thawing, do not re-freeze.
5. Vials may be stored refrigerated between 2° to 8°C (36° to 46°F) **for up to 30 days prior to first use**



**10 DOSES PER VIAL**

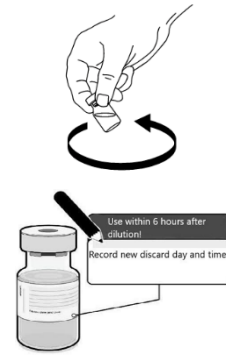
**Vaccine - Administration**

1. Withdraw the required 0.5 mL dose of vaccine using a sterile needle and syringe.
2. Check that there are no particulates or discolorations present in the vaccine prior to administration
3. Choose correct needle length (1" or 1.5") to reach muscle, prep skin with alcohol swab, and stabilize/stretch skin if excess soft tissue (do not bunch skin)
4. Inject 0.5 mL of the vaccine intramuscularly in the deltoid muscle of the arm
5. Cover injection site with bandage



## Vaccine - Ongoing Handling and Storage

1. Swirl vial gently after thawing and between each withdrawal. **DO NOT** shake. **DO NOT** dilute the vaccine.
2. After the first dose has been withdrawn:
  - the vial should be held between 2° to 25°C (36° to 77°F)
  - record the date and time for first use on the vial label.
  - discard vial after 6 hours. **DO NOT** re-freeze.



## Vaccine - Adverse Event Monitoring and Management

**Monitor for adverse reactions (e.g. anaphylaxis) for a minimum of 15 minutes and initiate immediate treatment (below) as needed**

- If mild injection site reaction or allergic reaction consult ordering physician/On-Line Medical Control (OLMC) for management
- If signs of severe allergic reaction/anaphylaxis (dyspnea, stridor, severe urticaria, tachycardia, hypotension, or Altered Mental Status) activate emergency response system and initiate treatment if available:
  - Epinephrine 0.3 mg (1 mg/mL concentration) intramuscular (may use epinephrine auto-injector if available)
  - Perform airway management per local EMS protocols
  - Establish intravenous/intraosseous
  - Initiate cardiac monitoring
  - Diphenhydramine 50 mg intravenous, intramuscular or intraosseous
  - Albuterol 2.5 mg nebulized if wheezing/dyspnea, may repeat x 1
  - Initiate transport per local EMS protocols
  - Consult OLMC for additional epinephrine/push dose pressor as needed
- Report any adverse reactions

## Documentation

- Use provided forms to document vaccine manufacturer, injection site, lot number and expiration date.

## References

- [Vaccines and Related Biological Products Advisory Committee December 17, 2020 Meeting Presentation- FDA Review of Efficacy and Safety of Moderna COVID-19 Vaccine EUA](#)
- <https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html>
- <https://www.modernatx.com/covid19vaccine-eua/>

**FACT SHEET FOR RECIPIENTS AND CAREGIVERS**  
**EMERGENCY USE AUTHORIZATION (EUA) OF**  
**THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019**  
**(COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER**

You are being offered the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Moderna COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Moderna COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Moderna COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Moderna COVID-19 Vaccine.

The Moderna COVID-19 Vaccine is administered as a 2-dose series, 1 month apart, into the muscle.

The Moderna COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit [www.modernatx.com/covid19vaccine-eua](http://www.modernatx.com/covid19vaccine-eua).

**WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE**

**WHAT IS COVID-19?**

COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

**WHAT IS THE MODERNA COVID-19 VACCINE?**

The Moderna COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the “**What is an Emergency Use Authorization (EUA)?**” section at the end of this Fact Sheet.

## **WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE MODERNA COVID-19 VACCINE?**

Tell your vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

## **WHO SHOULD GET THE MODERNA COVID-19 VACCINE?**

FDA has authorized the emergency use of the Moderna COVID-19 Vaccine in individuals 18 years of age and older.

## **WHO SHOULD NOT GET THE MODERNA COVID-19 VACCINE?**

You should not get the Moderna COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine

## **WHAT ARE THE INGREDIENTS IN THE MODERNA COVID-19 VACCINE?**

The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.

## **HOW IS THE MODERNA COVID-19 VACCINE GIVEN?**

The Moderna COVID-19 Vaccine will be given to you as an injection into the muscle.

The Moderna COVID-19 Vaccine vaccination series is 2 doses given 1 month apart.

If you receive one dose of the Moderna COVID-19 Vaccine, you should receive a second dose of the same vaccine 1 month later to complete the vaccination series.

## **HAS THE MODERNA COVID-19 VACCINE BEEN USED BEFORE?**

The Moderna COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 15,400 individuals 18 years of age and older have received at least 1 dose of the Moderna COVID-19 Vaccine.

## **WHAT ARE THE BENEFITS OF THE MODERNA COVID-19 VACCINE?**

In an ongoing clinical trial, the Moderna COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 1 month apart. The duration of protection against COVID-19 is currently unknown.

## WHAT ARE THE RISKS OF THE MODERNA COVID-19 VACCINE?

Side effects that have been reported with the Moderna COVID-19 Vaccine include:

- Injection site reactions: pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness
- General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

There is a remote chance that the Moderna COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Moderna COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

These may not be all the possible side effects of the Moderna COVID-19 Vaccine. Serious and unexpected side effects may occur. The Moderna COVID-19 Vaccine is still being studied in clinical trials.

## WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to <https://vaers.hhs.gov/reportevent.html>. Please include “Moderna COVID-19 Vaccine EUA” in the first line of box #18 of the report form.

In addition, you can report side effects to ModernaTX, Inc. at 1-866-MODERNA (1-866-663-3762).

You may also be given an option to enroll in **v-safe**. **V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: [www.cdc.gov/vsafe](http://www.cdc.gov/vsafe).

**WHAT IF I DECIDE NOT TO GET THE MODERNA COVID-19 VACCINE?**

It is your choice to receive or not receive the Moderna COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

**ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES MODERNA COVID-19 VACCINE?**

Currently, there is no FDA-approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

**CAN I RECEIVE THE MODERNA COVID-19 VACCINE WITH OTHER VACCINES?**

There is no information on the use of the Moderna COVID-19 Vaccine with other vaccines.

**WHAT IF I AM PREGNANT OR BREASTFEEDING?**

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

**WILL THE MODERNA COVID-19 VACCINE GIVE ME COVID-19?**

No. The Moderna COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.


**KEEP YOUR VACCINATION CARD**

When you receive your first dose, you will get a vaccination card to show you when to return for your second dose of the Moderna COVID-19 Vaccine. Remember to bring your card when you return.

**ADDITIONAL INFORMATION**

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

<b>Moderna COVID-19 Vaccine website</b>	<b>Telephone number</b>
<a href="http://www.modernatx.com/covid19vaccine-eua">www.modernatx.com/covid19vaccine-eua</a> 	1-866-MODERNA (1-866-663-3762)

**HOW CAN I LEARN MORE?**

- Ask the vaccination provider
- Visit CDC at <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- Visit FDA at <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>
- Contact your state or local public health department

### **WHERE WILL MY VACCINATION INFORMATION BE RECORDED?**

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs, visit: <https://www.cdc.gov/vaccines/programs/iis/about.html>.

### **WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?**

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit [www.hrsa.gov/cicp/](http://www.hrsa.gov/cicp/) or call 1-855-266-2427.

### **WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?**

The United States FDA has made the Moderna COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

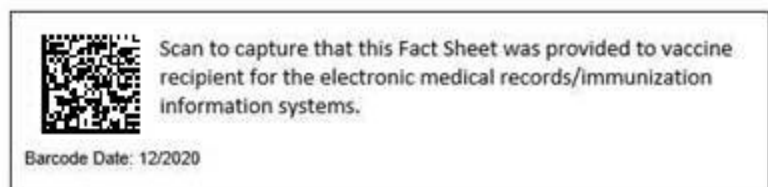
The Moderna COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of the scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Moderna COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

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Patent(s): [www.modernatx.com/patents](http://www.modernatx.com/patents)

Revised: 12/2020







## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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### USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

This authorization will have an expiration date that can be revoked by you in writing.

#### INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

## DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at <http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html> and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

#### COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

#### FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

#### EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

#### REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).  
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).



Administration Facility Name/Facility ID: \_\_\_\_\_

## COVID-19 VACCINE SCREENING AND CONSENT FORM

### Moderna COVID-19 Vaccine

**SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT)**

<b>Name:</b> Last: _____ First: _____ Middle Initial: _____							
<b>Date of Birth:</b> Month _____ Day _____ Year _____	<b>Mobile Phone Number (Patient or Guardian):</b> ( _____ ) _____						
<b>Address:</b> _____ <b>Apt/Room #:</b> _____							
<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____							
<b>Sex</b> (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male	<table border="0" style="width: 100%;"> <tr> <td style="width: 33%;"><b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American</td> <td style="width: 33%;"><input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White</td> <td style="width: 33%;"><input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander</td> </tr> <tr> <td colspan="3"><b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown</td> </tr> </table>	<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American	<input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Other Pacific Islander					
<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown							
<b>Primary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____							
<b>Secondary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____ Insurance Company : _____ Insurance Company Phone # _____ Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____							
<b>Is this the patient's first or second dose of the COVID-19 vaccination?</b> <input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose							

**SECTION 2: COVID-19 SCREENING QUESTIONS**

Please check YES or No for each question.	Yes	No
1. Are you sick today?		
2. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding		
6. Have you had any other vaccinations in the previous 14 days?		
7. In the past two weeks, have you tested positive for COVID-19?		
8. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?		

**SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE**

Please check YES or No for each question.	Yes	No
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:		

- 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) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida 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 after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH), 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 Florida SHOTS, Florida's immunization registry and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH 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 DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

**Signature of Patient or Authorized Representative** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name of Representative and Relationship to Person Receiving Vaccine:** \_\_\_\_\_

Site (LD/RD)	Route	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
	IM				

<b>Administered at location: facility name/ID</b>	
<b>Administered at location: Type</b>	
<b>Administration Address:</b>	
<b>CVX (product)</b>	
<b>Sending organization:</b>	

**Vaccinator Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Vaccine administering provider suffix:** \_\_\_\_\_