

Eligibility to receive COVID-19 vaccine in the State of Alabama

Confirm by checking below which category qualifies you for vaccination:

- 55 years or older
- 16 – 64 years of age **WITH** high-risk medical conditions (for example: cancer; chronic kidney disease; COPD; heart conditions such as heart failure, coronary artery disease or cardiomyopathies; immunocompromised state; solid organ transplant; obesity BMI >30 kg/m²; sickle cell disease; smoking; type 1 and 2 diabetes; pregnancy;)
- Healthcare Worker
- Emergency Medical Services or First Responder (Fire and Law Enforcement)
- Childcare Worker
- Teacher (K – 12, Community College or any institutions of higher learning)
- Grocery Worker
- Public Safety/ Energy Worker
- Public Transit/Transportation and Logistics Worker
- Information Technology and Communication/ Media Worker
- Waste and Wastewater Worker
- Food Service Worker
- Agricultural Worker
- Manufacturing Worker
- Shelter and Housing (Construction) Worker
- Financial/Bank Worker
- Corrections Officer/Staff
- People with intellectual and developmental disabilities

Andalusia Health COVID-19 Vaccine Questionnaire

Date of Vaccination: _____

Vaccine Recipient Name: _____

Date of Birth: _____ Age: _____

Home Address: _____

Mother's Maiden Name: _____

1. Are you an employee or contract employee of Andalusia Health? **YES or NO**
 - a. If yes, what department? Must provide proof with Andalusia Health issued employee badge.

 - b. If no, who is your employer? What is your position with your employer? Must provide identification of employer.

2. Are you aware that the **Moderna** COVID19 vaccine series consist of two inoculations 28-days apart? **YES or NO**
 - a. *You will be expected to return for vaccination on your scheduled date, please notify the COVID Vaccine Coordinator, Scott Riley, or Employee Health, Brooke Greathouse, if unable prior to scheduled date.*

Circle YES or No to the questions below. If you answer YES to any of the questions below OR have a fever day of (>100°F), you may not be eligible for the vaccine. Additional questions may be asked.

1. Are you less than 18 years old? **YES or NO**
2. Are you feeling sick today? **YES or NO**
3. Do you have a fever? **YES or NO**
4. Have you tested positive with COVID-19 or had a medical provider told you that you had COVID-19 in the last 90 days? **YES or NO**
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? **YES or NO**
6. Have you had a severe allergic reaction to previous vaccinations? **YES or NO**
7. Have you received any vaccinations in the last 4 weeks? **YES or NO**
8. Do you have a weakened immune system caused by something such as HIV infection, cancer, or taking immunosuppressive drugs or therapies? **YES or NO**
9. Have you received a COVID-19 vaccination from a different manufacturer or facility? **YES or NO**
10. Are you currently pregnant or breastfeeding? **YES or NO**
11. Do you have a bleeding disorder or are on a blood thinner? **YES or NO**

COVID–19 Vaccination Consent Form

COVID-19 VACCINE:

COVID-19 vaccines will help prevent a disease that can be dangerous, or even deadly. Authorized or approved vaccines will help reduce the risk of disease by working with the body's natural defenses to safely develop protection (immunity) to disease. COVID-19 vaccines help our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness. It typically takes a few weeks for the body to develop immunity to the virus after vaccination. Therefore, it is possible that a person could be infected with the virus that causes COVID-19 just before or just after vaccination and then get sick because the vaccine did not have enough time to provide protection.

Sometimes after vaccination, the process of building immunity can cause symptoms, such as fever. These symptoms are normal and are a sign that the body is building immunity. The vaccine is NOT a live virus and will not give you COVID-19.

RISKS & POSSIBLE SIDE EFFECTS:

COVID-19 vaccines have shown to generally cause only mild side effects. Most commonly, reactions may be soreness or tenderness at the injection site, fever, chills, fatigue, headaches or muscle aches. These effects usually last 24 to 48 hours. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, medical events completely unrelated to vaccine administration may occur coincidentally in the period following vaccination.

At this time, the COVID–19 vaccine may not be recommended for certain individuals due to age thresholds or other specific conditions based on the FDA Emergency Use Authorization (EUA) Patient Fact Sheets. Please review the manufacturer FDA EUA Patient Fact Sheets for a full list of contraindications and precautions.

If any contraindication within the FDA EUA Patient Fact Sheet applies to you, please notify the staff. If you have any questions, please ask now or check with your physician or health department before receiving the vaccine.

IF YOU EXPERIENCE ANY SIGNIFICANT REACTIONS, CONTACT YOUR PHYSICIAN.

I have read the above information about COVID-19 and the COVID-19 vaccine EUA Patient Fact Sheet with patient education information, and I have had a chance to ask questions. I understand the benefits and risks of the COVID–19 vaccination and request that the vaccine be given to me.

NAME (Please Print)

Date of Birth

Phone Number

SIGNATURE

Date/Time

COVID-19 Vaccination Consent Form

Dose #1:

Vaccine Manufacturer: Moderna

Lot #: 029A21A Expiration date: 05/22/2021 Site (IM): RIGHT LEFT DELTOID

Administered by: _____ Date / Time _____

Dose #2 when applicable:

Dose #2 from the same manufacturer as Dose #1 will be due on or after: _____
[INSERT DATE HERE]

Vaccine Manufacturer: Moderna

Lot #: _____ Expiration date: _____ Site (IM): RIGHT LEFT DELTOID

Administered by: _____ Date / Time _____



CONSENT FOR SERVICES AND FINANCIAL RESPONSIBILITY

Please read carefully and sign the necessary authorizations, releases and agreements so that we may proceed with the care and treatment ordered by your physician.

- 1. CONSENT TO HOSPITAL SERVICES:** I understand that a patient's care is directed by his/her attending physician(s) and I consent to any hospital services that are appropriate for my care and as ordered by my physician(s).
- 2. MEDICAL EDUCATION:** I understand that residents, interns, medical students, nursing or other students and trainees may observe, examine, treat and participate, with supervision, in my care as part of medical education programs.
- 3. PATIENT'S CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act (Medicare) is correct. If I am a recipient of Medicare, I understand that I am responsible for the Medicare deductible, the co-insurance, life-time reserve days, if applicable, and the 20% Part B co-insurance for professional charges. I hereby irrevocably assign payment of all hospitalization and medical benefits applicable and otherwise payable to me to the hospital and to all clinical providers providing care to me at the hospital. Unless otherwise stated in the insurance contract, precertification is ultimately a patient responsibility.
- 4. FINANCIAL AGREEMENT:** I, the undersigned, in consideration of the services to be rendered to the patient, am obligated to promptly pay the hospital in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. The hospital may provide, upon my request, a reasonable estimate of charges for items and services based on the hospital's charge description master. If any account is referred to an attorney or collection agency for collection, I agree to pay reasonable attorney's fees and collection expenses. I understand that, as a courtesy to me, the Hospital may bill my insurance company or health benefit plan, but is not required to do so. I agree and understand that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the undersigned. I further understand that the obligation to pay the hospital may not be deferred for any reason, including pending legal actions against other parties to recover medical costs. The Hospital shall determine whether and when an account is in default due to non-payment of the balance on the account. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist, and others, will bill separately for their services.
- 5. HOSPITAL TO ACT AS AGENT:** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan (including an employer-sponsored health benefit plan), or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurers or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment. I also hereby authorize the Hospital, or the Hospital's designee, to act on my behalf in any dispute with a managed care organization, government health program, any insurance plan or any employer-sponsored health benefit plan with respect to benefits available under such plan. This authorization specifically includes the authorization to file any appeal on my behalf from a denial of benefits and to act as my agent in pursuing such appeals.
- 6. CONSENT TO WIRELESS TELEPHONE CALLS AND TEXT MESSAGES:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the hospital to the contrary in writing. In this section, calls and text messages include but is not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the hospital, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.
- 7. CONSENT TO EMAIL USAGE:** If at any time I provide an email address at which I may be contacted, unless I notify the hospital to the contrary in writing, I consent to receiving discharge instructions, statements, bills, marketing material for new services and payment receipts at that email address from the hospital.



8. **OUTPATIENT MEDICARE PATIENTS:** Medicare does not cover prescription drugs except for a few exceptions. Per Medicare regulations you are responsible for any drugs furnished you while an outpatient that meet Medicare's definition of a prescription drug. These drugs are commonly referred to as self-administered drugs, as they are typically self-administered but can be administered by hospital personnel. Medicare requires hospitals to bill Medicare patients or other third party payers for these drugs. Medicare Part D beneficiaries may bill Medicare Part D for possible reimbursement of these drugs in accordance with Medicare Drug plan enrollment materials.
9. **INFECTION CONTROL CONSENT:** To protect against possible transmission of blood borne diseases, such as Hepatitis or Human Immunodeficiency Virus (AIDS, HIV), I understand it may be necessary or medically indicated to test my blood while I am a patient of the hospital if, for example, a hospital employee is stuck by a needle while drawing blood, is splashed with blood, or sustains a scalpel injury and is exposed to my blood. I understand my blood, as well as the employee's blood will be tested for possible infection with the above mentioned diseases. The test results of both employee and patient will be kept confidential as provided by law.
10. **RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS AND OTHER HEALTH CARE PROVIDERS:** I understand that most or all of the health care providers performing services in this Hospital are independent contractors and are not Hospital employees, representatives or agents. Most physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist, hospitalist and others, are independent contractors and are not employees, representatives or agents of the hospital. Likewise, most physician assistants (PA's), Nurse Practitioners (NP's), and Certified Registered Nurse Anesthetists (C.R.N.A.'s) are independent contractors and are not employees, representatives or agents of the hospitals. Independent contractors are responsible for their own actions and the Hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that I may ask my Health Care Provider to verify if they are a Hospital employee or an independent contractor.

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

I understand that physicians providing care at this hospital may be NON-PARTICIPATING providers in my insurance plan and will bill me for their professional services separately from the Hospital bill.

11. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION AT DISCHARGE:** I authorize Hospital to provide a copy of the medical record of my treatment, the discharge summary, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) identified on my discharge paperwork to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this admission, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.
12. **ELECTION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE(S):** I hereby authorize Hospital to provide a copy of my medical record or portions thereof to any health information exchange or network with which Hospital participates and to any other participant in such health information exchange or network for purposes of treatment, payment, and health care operations and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or network with which Hospital participates may be found in the Notice of Privacy Practices, which is available on the Hospital website, and this list may be updated from time to time if and when Hospital participates with new health information exchanges or networks. Hospital participates in the LifePoint health information exchange, which is operated by business associates of Hospital identified in the Notice of Privacy Practices, including LifePoint Corporate Services General Partnership. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

13. **NOTICE OF PRIVACY PRACTICES:** I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of my health care information uses and disclosures.
14. **PATIENT DIRECTORY PREFERENCE:** I have been informed that unless I object, the hospital can use a facility directory to inform visitors or callers, if they ask for me by name, about my location in the facility and general medical condition. Clergy may also receive this information as well as my religious affiliation.
- I object to having my name, location and general condition listed in the facility directory.
15. **ELECTION TO REQUEST INTERPRETIVE SERVICES:** In accordance with Sect. 60, of Title VI, the Hospital is committed to ensuring that all patients receive equal access to medical care. To achieve this goal, interpretive services may be utilized or requested at no cost to you.
16. **PATIENT RIGHTS:** I have received a copy of the Patient Rights. I understand these rights and if I have further questions, I will ask the nursing staff.
17. **CONSENT TO PHOTOGRAPH:** I consent to photographs, video or other images where deemed medically necessary by my physician before, during, or after a procedure. This is to provide documentation of my treatment and medical condition and will be kept as a part of my medical record.
18. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of my Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.
- I have executed an Advance Directive
- I have not executed an Advance Directive
- I would like to formulate an Advance Directive and receive additional information
19. **OTHER ACKNOWLEDGEMENTS:**
- a. **Personal Valuables:** I understand that I am responsible for all my personal effects, including personal grooming articles, clothing, eyeglasses, contact lenses, hearing aids, dentures, other prosthetic devices, electronic devices such as cell phones, laptops, electronic readers, iPads/Pods and all other such devices. I understand and agree that the hospital maintains a safe for the safekeeping of money and other valuables; however, except as required by law, the hospital is not liable for any loss or damage to property that is secured in the safe.
- b. **Smoke Free Facility Policy:** The Hospital is a smoke free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.
- c. **Weapons / Explosives / Drugs:** I understand and agree that the hospital is a weapons, explosives, illegal substance or drug and alcohol free facility. I understand that while I am a patient at the Hospital I may not have these items in my room or with my belongings. If the hospital believes I have any of the above mentioned items the hospital may search my room and belongings. If found, the items may be confiscated, disposed appropriately or turned over to the law enforcement authorities.
20. **MATERNITY PATIENTS:** If I deliver an infant(s) while a patient of this hospital, I agree that each provision of this Consent for Services and Financial Responsibility applies to the infant(s).

I have read and fully understand this Patient Consent and Financial Agreement and been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Signature of Patient or Legal Representative for Health Care Hospital Services if Other Than Patient

Date and Time

Relationship to Patient

Reason Individual is Unable to Sign, i.e., Minor or Legally Incompetent

Signature of Witness

Date and Time

**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.

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.

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.

Moderna COVID-19 Vaccine website	Telephone number
www.modernatx.com/covid19vaccine-eua 	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/ 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

Revised: 12/2020



Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 12/2020



**Get vaccinated.
Get your smartphone.
Get started with v-safe.**

What is v-safe?

V-safe is a smartphone-based tool that uses text messaging and web surveys to provide personalized health check-ins after you receive a COVID-19 vaccination. Through **v-safe**, you can quickly tell CDC if you have any side effects after getting the COVID-19 vaccine. Depending on your answers, someone from CDC may call to check on you. And **v-safe** will remind you to get your second COVID-19 vaccine dose if you need one.

Your participation in CDC's **v-safe** makes a difference—it helps keep COVID-19 vaccines safe.

How can I participate?

Once you get a COVID-19 vaccine, you can enroll in **v-safe** using your smartphone. Participation is voluntary and you can opt out at any time. You will receive text messages from **v-safe** around 2 p.m. local time. To opt out, simply text "STOP" when **v-safe** sends you a text message. You can also start **v-safe** again by texting "START."

How long do v-safe check-ins last?

During the first week after you get your vaccine, **v-safe** will send you a text message each day to ask how you are doing. Then you will get check-in messages once a week for up to 5 weeks. The questions **v-safe** asks should take less than 5 minutes to answer. If you need a second dose of vaccine, **v-safe** will provide a new 6-week check-in process so you can share your second-dose vaccine experience as well. You'll also receive check-ins 3, 6, and 12 months after your final dose of vaccine.

Is my health information safe?

Yes. Your personal information in **v-safe** is protected so that it stays confidential and private.*



Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.



Sign up with your smartphone's browser at vsafe.cdc.gov

OR

Aim your smartphone's camera at this code



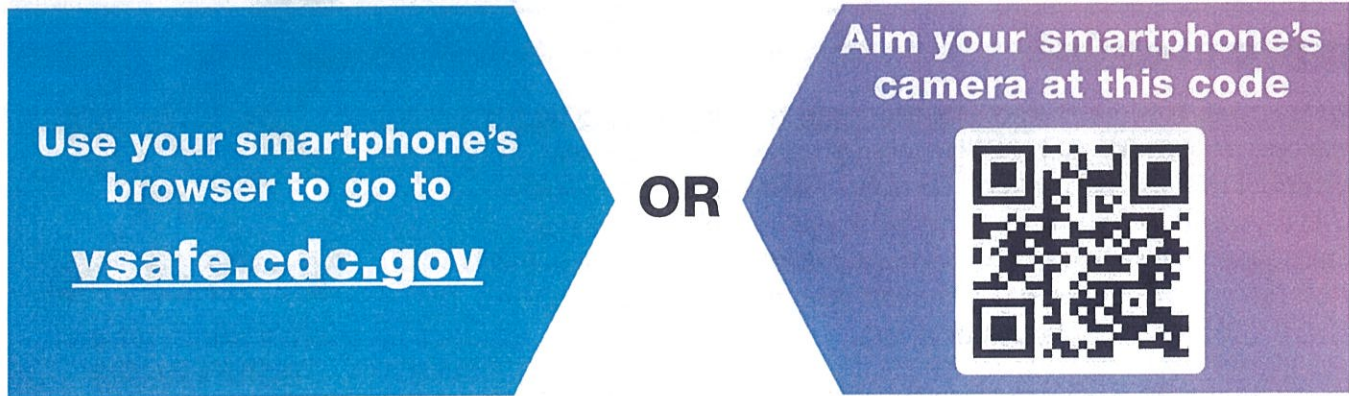
*To the extent **v-safe** uses existing information systems managed by CDC, FDA, and other federal agencies, the systems employ strict security measures appropriate for the data's level of sensitivity.

How to register and use v-safe

You will need your smartphone and information about the COVID-19 vaccine you received. This information can be found on your vaccination record card; if you cannot find your card, please contact your healthcare provider.

Register

1. Go to the **v-safe** website using one of the two options below:



2. Read the instructions. Click **Get Started**.
3. Enter your name, mobile number, and other requested information. Click **Register**.
4. You will receive a text message with a verification code on your smartphone. Enter the code in **v-safe** and click **Verify**.
5. At the top of the screen, click **Enter vaccine information**.
6. Select which COVID-19 vaccine you received (found on your vaccination record card; if you cannot find your card, please contact your healthcare provider). Then enter the date you were vaccinated. Click **Next**.
7. Review your vaccine information. If correct, click **Submit**. If not, click **Go Back**.
8. **Congrats! You're all set!** If you complete your registration before 2 p.m. local time, **v-safe** will start your initial health check-in around 2 p.m. that day. If you register after 2 p.m., **v-safe** will start your initial health check-in immediately after you register—just follow the instructions. You will receive a reminder text message from v-safe when it's time for the next check-in — around 2 p.m. local time. Just click the link in the text message to start the check-in.

Complete a v-safe health check-in

1. When you receive a **v-safe** check-in text message on your smartphone, click the link when ready.
2. Follow the instructions to complete the check-in.

Troubleshooting

How can I come back and finish a check-in later if I'm interrupted?

- Click the link in the text message reminder to restart and complete your check-in.

How do I update my vaccine information after my second COVID-19 vaccine dose?

- **V-safe** will automatically ask you to update your second dose information. Just follow the instructions.

Need help with v-safe?

Call 800-CDC-INFO (800-232-4636)

TTY 888-232-6348

Open 24 hours, 7 days a week

Visit www.cdc.gov/vsafe

