THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: 9/14/2022; SEX: FC:

Moderna COVID-19 Vaccine Attestation

Please read completely and attest to your understanding and agreement of the following. I declare that I:

- I am 18 years of age and older;
- Have received information about the possible side effects of the FDA-approved SPIKEVAX (COVID-19 Vaccine, mRNA) the Moderna COVID-19 or the Moderna COVID-19 Vaccine, Bivalent (Original and Omicron BA.4/BA.5) Vaccine under Emergency Use Authorization.
- Voluntarily agree to receiving all of the necessary COVID-19 doses at MD Anderson, after carefully considering the risks and benefits;
- Have not recently tested positive for COVID-19, and if so, have completed the 7-day quarantine before the vaccine appointment;
- Am aware there may be unknown side effects of the COVID-19 vaccine;
- Should consult with my medical provider to discuss my personal risks and benefits of receiving the COVID-19 vaccine;
- Understand that if I have ever experienced a severe allergic reaction, I may have a greater risk of experiencing a severe allergic reaction to the Moderna COVID-19 vaccine (including problems breathing, swelling of the face and throat, a fast heartbeat, a bad rash all over the body, dizziness, and weakness);
- Understand that I should proceed with caution if I have ever experienced a severe allergic reaction to a vaccine or medicine injected in my skin, muscle, or veins, and I that should discuss with my personal medical provider whether or not to receive the Moderna COVID-19 vaccine at this time;
- Understand that I <u>should not</u> receive the Moderna COVID-19 vaccine if I have ever experienced a severe allergic reaction to a component of this vaccine, which includes polyethylene glycol (used in many injectable medications), tromethamine and tromethamine hydrochloride, sodium acetate, acetic acid, sucrose, and cholesterol;
- Understand that I must remain in a designated observation area for 15-30 minutes after my vaccination so that on-site medical staff can assist in case of a severe allergic reaction to the COVID-19 vaccine;
- Understand that if I experience a severe adverse reaction after I leave the designated observation area, I should call 9-1-1 or immediately go the nearest hospital emergency room (ER);

- Understand that the COVID-19 vaccines given at MD Anderson will be tracked and reported, as required by the state and federal government, and that information shared about me (or my child/minor), as part of this process, will be limited to my (or my child/minor's) full name, date of birth, gender, race, ethnicity, address, and whether I am school or childcare personnel;

- Acknowledge receipt of the UT MD Anderson Notice of Privacy Practices (NPP). I understand that a copy of the NPP is available to me at the time of vaccination, upon my request, or by reviewing on our website;

- Understand the importance of continuing to wear a mask, wash my hands,, and keep social distancing after receiving the COVID-19 vaccine; and

- I understand that my insurance may be billed for the COVID-19 vaccine administration fee, and that my insurance carrier should process the vaccine administration charge without applying any out-of-pocket costs to me.

_____ _____

Printed Name of Patient or Child's Parent/Legal Next of Kin Date

_____

Relationship to Child/Minor (if applicable)

_____

Signature of Patient or Child's Parent/Legal Next of Kin