North Central Health Care
Person centered. Outcome focused.

COVID-19 Vaccination Employee Statement

I am aware of the COVID-19 vaccination policy and have had a chance to have my questions answered about COVID-19 vaccination. I understand the benefits and risks of the vaccine, and by signing below I **agree** to have the 2024-2025 COVID-19 vaccine.

_________________________________ ____________________ __________________
Print Name Date of Birth Today's Date

_________________________________ ___________________________________
Signature Program

_________________________________ _________________________________
Parent/Guardian signature (if under age 18) Today's Date

COVID-19 Vaccination Administration

COVID-19 vaccination screening questions:	Question		
	1) Are you sick today?	☐ Yes	☐ No
	2) Do you have any life-threatening allergies to a component of the COVID-19 vaccine? Please List:	☐ Yes	☐ No
	3) Have you had a life-threatening reaction to a COVID-19 vaccine in the past?	☐ Yes	☐ No

Administrative Use Only		
Name of Vaccination: COVID-19 Vaccine, mRNA		
Date administered/Education sheet given:____/____/______		Information for Recipients and Caregivers Sheet 10/19/2023
Vaccine: SPIKEVAX 12+ 2024-2025 Formula		
Lot #: 3043029 8080748 3043391	Mfg: Moderna	**Site:** ☐ **Left Deltoid** ☐ **Right Deltoid**
Dose: 0.5 ml.	Exp. Date: 5/24/2025 5/29/2025 5/30/2025	**Name and title of vaccine administrator:**

Documented in WIR Date and Initials: ________/_______