Covid-19 Vaccine Consent Form

Name: ________________________________ **Date**: ________________________

Date of Birth: _____________ **Age**: _______ **Phone Number**: ___________________

Address: ____

Name of Primary Care Physician: ____

Date of last Covid vaccine: ___________ ☐ Unknown ☐ Never received

1. Have you had a positive test for Covid-19? Yes No
2. Are you under 12 years old? Yes No
3. Do you have an allergy to any medications, food, vaccine, or latex? Yes No

   List all allergies: __________________________________
4. Do you have an allergy to Polyethylene Glycol or Polysorbate? Yes No
5. Do you currently have an acute illness or infection? Yes No
6. Are you on anticoagulation therapy or have a bleeding disorder? Yes No
7. Have you received any vaccines in the last 2 weeks? Yes No
8. Do you have an immune system weakened by HIV, cancer, or immunosuppressive drugs? Yes No
9. Have you received any antibody therapy as treatment for Covid-19? Yes No

If you answered yes to any of the above, you should NOT get a Covid-19 shot today or speak to our pharmacist for more details.

CONSENT:

I have read the above information and understand the risks and benefits of receiving this vaccine as stated in the VIS. I had the opportunity to ask questions regarding the Covid-19 vaccine. I request the vaccine to be given to me.

Signature: _____________________________________ Date: _________________

. . . .

Circle one: *SpikeVax (Moderna)* *or* *Comirnaty (Pfizer)* *(Sticker)*

Date of Vaccination: ______________ Site: 0.5 mL IM ☐ Right Deltoid ☐ Left Deltoid

Manufacturer: _______________ Lot #:______________ Expiration Date: ___________

Administered by: (Signature/Title) ________________________________