



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 recent 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: _____

FOR CLINIC USE ONLY:

SpikeVax (Moderna) (Sticker)

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

Manufacturer: _____ Lot #: _____ Expiration Date: _____

Administered by: (Signature/Title) _____



Attention: Dr. _____ Fax: _____

The following patient has received a **Spikevax (Moderna-Covid19)** vaccine.

<i>Date</i>	<i>Patient</i>	<i>Date of Birth</i>

Thank you,

The Medicine Shoppe Pharmacy