

3601 4TH St. Suite 1B300
Lubbock, TX 79430

Texas Tech School of Pharmacy
TTUHSC PHARMACY
Covid-19 Vaccination Consent Form

Phone: (806) 743-3270
Fax: (806) 743-3260

By Signing Below:

1. I agree that the person below will get the vaccine put in his/her body to prevent disease.
2. I received a copy of the emergency use authorization fact sheet for this vaccine.
3. I know the risks of the disease this vaccine prevents.
4. I know the benefits and risks of the vaccine. I know I may have pain, swelling, and erythema at the injection site, fatigue, headache, myalgia, arthralgia, chills, nausea/vomiting, axillary swelling/tenderness, fever, and additional adverse reactions, some of which may be serious.
5. I have had a chance to ask questions about the disease and the vaccine.
6. I state that the person getting the shot is in relatively good health today.
7. **I understand I should wait in the area for 15 minutes after I receive the vaccine.**
8. I am an adult who can legally consent for the person below to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.
9. I agree that this vaccine can be reported in the Texas Department of Health Immunization tracking system, to health care providers, schools, or other places that provide child care.

***AVAILABLE DATA ON MODERNA COVID-19 VACCINE ADMINISTERED TO PREGNANT WOMEN ARE INSUFFICIENT TO INFORM VACCINE-ASSOCIATED RISKS IN PREGNANCY. DATA ARE NOT AVAILABLE TO ASSESS THE EFFECTS OF MODERNA COVID-19 VACCINE ON THE BREASTFED INFANT OR ON MILK PRODUCTION/EXCRETION.**

Please check any of the boxes below that apply:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> *PREGNANCY
(SEE ABOVE) | <input type="checkbox"/> Chronic
Obstructive
Pulmonary
Disease | <input type="checkbox"/> Solid Organ
Transplantation | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Obesity | <input type="checkbox"/> Type 2 diabetes
mellitus |
| <input type="checkbox"/> Asthma | | <input type="checkbox"/> Chronic Kidney
Disease | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Cancer | | | _____ |

Last Name	First Name	MI	Sex	Age	Date of Birth	Telephone#
Address		City		State		Zip Code
Allergies and Reactions		Primary Care Provider			Social Security #	
Signature		Medicare #			Date:	
Statement: <ul style="list-style-type: none">• By signing above I authorize the release of any medical or other information necessary to process the claim.• I also request payment of government benefits to the party who accepts assignment.• I acknowledge receiving the TTUHSC Notice of Privacy Practices.						

Moderna	021C21A	10/21/2021	Moderna Covid-19 Vaccine 0.5ml IM	Prescription Insurance Card Information: ID: _____ BIN: _____ PCN: _____ GRP: _____
Manufacturer	Lot #	Exp Date		
Deltoid	12/20			
Site of Injection	Date of EUA			
Signature & Title of Administrator/Date Given				