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Texas Tech School of Pharmacy

TTUHSC PHARMACY

Phone: (806) 743-3270
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Covid-19 Vaccination Consent Form

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:

- ☐ ***PREGNANCY (SEE ABOVE)**
- ☐ Latex allergy
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Heart Conditions
- ☐ Solid Organ Transplantation
- ☐ Obesity
- ☐ Chronic Kidney Disease
- ☐ Sickle Cell Disease
- ☐ Type 2 diabetes mellitus
- ☐ Other____________ __________________

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	Date

Statement:

- 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.

Manufacturer	Lot #	Exp Date
Moderna	**037K20A**	**6/22/2021**

Site of Injection	Date of EUA
Deltoid	12/20

Signature &Title of Administrator/Date Given

Moderna
Covid-19 Vaccine
0.5ml IM

Prescription Insurance Card Information:

ID:______________________

BIN:______________________

PCN:______________________

GRP:______________________