FLOWER MOUND PHARMACY
making your health our business

Covid-19 Vaccine Consent

Complete all questions and sign below (PLEASE PRINT CLEARLY)

Name: _____ Date of Birth:___/___/___

Address: _____ City, State, Zip:_____

Phone: _____Allergies:_____

Race: White/Black/Asian/Hispanic/Other
Ethnicity: Hispanic/Nonhispanic

Male Female

Yes	No	
☐	☐	Are you feeling sick today?
☐	☐	In the last 10 days have you had a COVID-19 test or been told by a healthcare Provider to isolate or quarantine due to COVID-19 infection or exposure?
☐	☐	Are you on quarantine because of travel requirements?
☐	☐	Have you been treated with antibody therapy for COVID-19 in the past 90 days?
☐	☐	Have you had any vaccines in the past 14 days, including the flu shot?
☐	☐	Are you pregnant or considering becoming pregnant?
☐	☐	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?
☐	☐	Do you take any medications that affect your immune system, such as steroids, anti-cancer drugs or have you had any radiation treatments recently?
☐	☐	Are you allergic to PEG (polyethylene glycol) or polysorbate which is found in some medications, such as laxatives and preparations for colonoscopy procedures?
☐	☐	

I voluntarily request and consent to the administration of the vaccine, and release Flower Mound Pharmacy and Herbal Alternatives and its employees from responsibility and liability for any consequences resulting from the administration of the vaccine.

SIGNATURE:_____ DATE:_____

Information below to be completed by Flower Mound Pharmacy Staff only
Covid Moderna Lot #_____ Site of administration: L or R deltoid
Given by:_____ Date:_____