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moukdad MEDICAL

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VACCINATION / INJECTION CONSENT FORM

This form authorizes Moukdad Medical to administer vaccines or injectable medications.
Please review and sign below to confirm your understanding and consent.

Patient Name: _____

Date of Birth: _____ **Phone:** _____

INJECTION / VACCINE INFORMATION

☐ B12 ☐ Testosterone ☐ Ketorolac ☐ Flu ☐ Other: _____

SCREENING QUESTIONS

Please check all that apply:

☐ I am currently ill or running a fever.
☐ I have allergies to any medications, latex, or vaccines.
☐ I have ever had a serious reaction to a vaccine or injection.
☐ I am pregnant or breastfeeding.
☐ I am on a blood thinner or have a bleeding disorder.

If any boxes are checked, please discuss with your provider before receiving the injection

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CONSENT TO TREATMENT

I have reviewed and understand the purpose, benefits, and potential side effects of the injection or vaccine listed above. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I understand that as with any medical procedure, reactions can occur, including local discomfort, redness, or swelling at the injection site, and in rare cases, allergic reactions.

I authorize Moukdad Medical and its clinical staff to administer the injection or vaccine

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PATIENT ACKNOWLEDGMENT

I hereby release Moukdad Medical and its staff from any liability that may arise from the administration of this injection, except as provided by law.

Patient Signature: _____ **Date:** _____

FOR OFFICE USE ONLY
Medication/Vaccine Name: _____ **Site of Administration:** ☐ Left Arm ☐ Right Arm ☐ Other: _____
Lot #: _____ **Expiration Date:** _____
Administered by: _____ **Date:** _____