



### 2020-2021 COVID-19 Vaccine Consent

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: Belinda M. Young  
(First Name, Middle Initial, Last Name)  
Date of Birth: 09/28/1959 Social Security Number: 258-17-7023  
Phone #: 334-244-3960 Email: byoung11@aum.edu  
Patient Address: 7755 Steele Ridge Dr Montgomery, AL 36117  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: XX  
Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: XX Unspecified: \_\_\_\_\_  
Race: White: XX African American: \_\_\_\_\_ Asian: \_\_\_\_\_  
American Indian: \_\_\_\_\_ Native Hawaiian: \_\_\_\_\_ Other: \_\_\_\_\_

| Please answer each question listed below:                                                                                | Yes | No |
|--------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1.) Do you have a severe allergy (hypersensitivity) to any component of the vaccine?                                     |     | XX |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | XX |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     |    |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | XX |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | XX |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | XX |
| 7.) Have you received another COVID-19 vaccine?                                                                          |     | XX |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     | XX |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | XX |

I have read and understand the **2020-2021 COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS** (dated **12/2020**). I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine. I have had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Belinda M. Young

(Print Name)

Belinda M. Young

(Sign Name)

2-15-2021

(Date)

**Staff Use Only**

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE    | SITE            | DATE/TIME RECEIVED           | Administered By: |
|---------------|---------------|-----------------|---------------|-----------------|------------------------------|------------------|
| <u>Pfizer</u> | <u>EN6200</u> | <u>6/21</u>     | <u>0.3 mL</u> | <u>(R) Delt</u> | <u>2/15/21</u><br><u>911</u> | <u>Smith</u>     |

Next Appointment Date/Time: 3/6/21

**\*\*\*If you present to the Emergency Department for any treatment, please inform the staff you have received the**

**COVID-19 vaccine. \*\*\***