

Booster
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COVID- 19 Vaccine Consent

Name: Lois M. Contell Birthday: 9-2-71
(First Name, Middle Initial, Last Name)

Phone #: 334-531-5323 Email: lois.contell@gmail.com

Address: 1343 Woodward Av. MGH 36106
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: Y Ethnicity: Hispanic: _____ Non-Hispanic: Y Unspecified: _____
Race: White: Y 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?			<u>X</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			<u>X</u>
3.) Do you have a bleeding disorder or are on a blood thinner?			<u>X</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			<u>X</u>
5.) Do you currently have an acute illness and/or high fever?			<u>X</u>
6.) Are you immunocompromised or on a medication that affects your immune system?			<u>X</u>
7.) Have you received another COVID-19 vaccine? If Yes, Vaccine Name: <u>10-29-21</u> Date Received: <u>Pfizer</u>		<u>Y</u>	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			<u>X</u>

I have read and understand the **COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS (Revised 5/2022)**. I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine and had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Lois M. Contell [Signature] 7-20-22
(Print Name) (Sign Name) (Date)

-----Staff Use Only-----

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>pfi zer</u>	<u>FM7553</u>	<u>7/31/22</u>	<u>0.3mL Im</u>	<u>L Deltoid</u>	<u>7:20:22 1:36pm</u>	<u>Daedra M</u>

***If you present to the Emergency Department for any treatment, please inform the staff you have received the COVID-19

vaccine. ***