

Baxter



COVID- 19 Vaccine Consent

Name: Dana G. Bice Birthday: 03/18/72
 (First Name, Middle Initial, Last Name)
 Phone #: 334-652-3778 Email: dbice1@aum.edu
 Address: 133 Salem Dr. Montgomery, AL. 36109
 (Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: ☒ Ethnicity: Hispanic: _____ Non-Hispanic: ☒ Unspecified: _____
 Race: White: ☒ 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?			no
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			no
3.) Do you have a bleeding disorder or are on a blood thinner?			no
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			no
5.) Do you currently have an acute illness and/or high fever?			no
6.) Are you immunocompromised or on a medication that affects your immune system?			no
7.) Have you received another COVID-19 vaccine? If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>8/29/22</u>		yes	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			no

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.

Dana G. Bice Dana G. Bice 1/13/23
 (Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer bivalent</u>	<u>6H9702</u>	<u>6/2023</u>	<u>0.3mL Im</u>	<u>L deltoid</u>	<u>1/13/23 3:03</u>	<u>Datedra M</u>

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

vaccine. ***