

Booster



COVID- 19 Vaccine Consent

Name: Timothy P. Bailey Birthday: 11/19/1969
(First Name, Middle Initial, Last Name)

Phone #: 334-398-0825 cell / 244-3420 wk Email: tbailey1@aum.edu

Address: 128 Bowen Bend Wetumpka AL 36093
(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?		☒
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		☒
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)		☐
5.) Do you currently have an acute illness and/or high fever?		☐
6.) Are you immunocompromised or on a medication that affects your immune system?		☐
7.) Have you received another COVID-19 vaccine? If Yes, Vaccine Name: <u>Pro</u> Date Received: <u>Aug 23, 2022</u>	☒	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		☒

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.

Timothy P. Bailey Tim P. Bailey 11/18/2022
(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>GH9702</u>	<u>6/2023</u>	<u>0.3mL IM</u>	<u>L deltoid</u>	<u>11/18/22 9:21am</u>	<u>Doretha M</u>

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

vaccine. ***