



## 2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Richard A Fleming  
(First Name, Middle Initial, Last Name)

Date of Birth: 2-13-1973 Social Security Number: 422-19-7397

Phone #: 334-399-6913 Email: hydroclean@aht.net

Patient Address: 2023 Red Hawk Rd Prattville, AL 36067  
(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?                                               |                                     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                                     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                                     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                                     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                                     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |                                     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |                                     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                | <input checked="" type="checkbox"/> |                                     |

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.

Richard Fleming Kelly J. J. J. 3-2-2022  
(Print Name) (Sign Name) (Date)

### Staff Use Only

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE           | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|-------------|----------------|--------------------|------------------|
| pfizer  | FJ0369 | 5/2022          | 0.3mL<br>IM | (L)<br>deltoid | 5/2/22<br>6:10/13  | Bicknell, RN     |

Next Appointment Date/Time: \_\_\_\_\_

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

COVID-19 vaccine. \*\*\*