

Booster



## COVID- 19 Vaccine Consent

Name: Micki Allen Birthday: 8/28/63  
 (First Name, Middle Initial, Last Name)  
 Phone #: 334/558-1196 Email: mallen24@aum.edu  
 Address: 1631 County Road 57 Prattville AL 36067  
 (Street) (City/ State) (Zip)

## Please Check One:

Gender: Male: \_\_\_\_\_ Female: X Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_  
 Race: White: X 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?<br>If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>12/10/21</u>    | <u>X</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.

Micki Allen Micki Allen 12/8/22  
 (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</u><br><u>Im.</u> | <u>① deltoid</u> | <u>12/8/2022</u><br><u>11:00</u> | <u>Bicknell, RN</u> |

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

vaccine. \*\*\*