



2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Ronnie B McKinney
(First Name, Middle Initial, Last Name)
Date of Birth: 4/4/1970 Social Security Number: _____
Phone #: 334-546-5495 Email: rmckinne@aum.edu
Patient Address: 21 Flagstone Dr 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>Pfizer</u> Date Received: <u>2/12/21 & 3/5/21</u>			
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			☒

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.

Ronnie McKinney [Signature] 10/12/2021
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>FC384</u>	<u>10/21</u>	<u>1M 0.3mL</u>	<u>(L) delt</u>	<u>10/12 3:14</u>	<u>J Frakes SN</u>

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. ***