



## 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Lynn L. Samuels  
(First Name, Middle Initial, Last Name)

Date of Birth: 6-16-48 Social Security Number: 227-76-2243

Phone #: 334-215-0572 Email: Aaron6900@aol.com

Patient Address: 8621 Lillian Pl. Montg. 36117  
(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?                                     |     | <input checked="" type="checkbox"/> |
| 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 type="checkbox"/>            |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3/5/21</u>                                                         |     |                                     |
| 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.

Lynn Samuels [Signature] 10-5-21  
(Print Name) (Sign Name) (Date)

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

| VACCINE | LOT #   | EXPIRATION DATE | DOSE/ROUTE  | SITE           | DATE/TIME RECEIVED | Administered By: |
|---------|---------|-----------------|-------------|----------------|--------------------|------------------|
| Pfizer  | 30135BA | 11/2021         | 0.3ml<br>1m | (L)<br>Deltoid | 10/19/21<br>1425   | m. Richardson    |

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. \*\*\*