

Booster



COVID- 19 Vaccine Consent

Name: Xinyue Ren Birthday: 06/22/1992  
(First Name, Middle Initial, Last Name)

Phone #: 334-398-5756 Email: xren@aum.edu

Address: \_\_\_\_\_  
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: \_\_\_\_\_ Female: X Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ Unspecified: \_\_\_\_\_

Race: White: \_\_\_\_\_ African American: \_\_\_\_\_ Asian: X 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: _____ Date Received: _____                      |     | <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.

Xinyue Ren Xinyue Ren 07/06/22  
(Print Name) (Sign Name) (Date)

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

| VACCINE | LOT #   | EXPIRATION DATE | DOSE/ROUTE  | SITE         | DATE/TIME RECEIVED | Administered By: |
|---------|---------|-----------------|-------------|--------------|--------------------|------------------|
| Pfizer  | Fm 7993 | July 31, 2022   | 0.3mL<br>Im | ①<br>Deltoid | 6/17/2022<br>10:02 | Bicknell, RN     |

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

vaccine. \*\*\*