

Booster- Bivalent



COVID- 19 Vaccine Consent

Name: Cornell Edison Foo Birthday: 06/27/75
 (First Name, Middle Initial, Last Name)
 Phone #: 706-614-5749 Email: cfoo@aum.edu
 Address: 1331 Hollwood Ln Montgomery 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?		X
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		X
3.) Do you have a bleeding disorder or are on a blood thinner?		X
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		X
5.) Do you currently have an acute illness and/or high fever?		X
6.) Are you immunocompromised or on a medication that affects your immune system?		X
7.) Have you received another COVID-19 vaccine? If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>12/10/21</u>		
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		X

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.

Cornell Foo [Signature] 10/1/22
 (Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer Bivalent	G1H9702	6/30/2023	0.3ml 1m	L deltoid	10/1/22 9:38am	Daedra M.

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

vaccine. ***