



COVID- 19 Vaccine Consent

Name: BENEDICT C OKEKE Birthday: 03/21/1962
(First Name, Middle Initial, Last Name)
Phone #: 334 328 1145 Email: bokeke@aum.edu
Address: 513 Stonebrook Way, Montgomery, AL 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? <u>81mg Aspirin</u>	✓	
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 FC3184</u> Date Received: <u>10/29/21</u>		X
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.

Benedict Okeke Jhulibun 11/21/22
(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>6H9702</u>	<u>6/2023</u>	<u>0.3mL</u> <u>Im subcut</u>	<u>L</u>	<u>11/21/22</u> <u>2:55</u>	<u>Doretha M</u>

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

vaccine. ***