



COVID- 19 Vaccine Consent

Name: MICHAEL S. WINKERMAN Birthday: 1/23/61
 (First Name, Middle Initial, Last Name)
 Phone #: (334) 303-3068 Email: MEBOVKIE@aol.com
 Address: 6630 KUSHKAW RD MONTICELLO, FL 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?			☒
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>12/17/21</u>			
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			☒

I have read and understand the **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.

MICHAEL WINKERMAN [Signature] 8/12/22
 (Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	FP 7137	11/2022	0.3mL 1m	Lt. Deltoid	2:05pm 8/12/22	J. Bonnet, CNP

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

vaccine. ***