

Booster
+



COVID- 19 Vaccine Consent

Name: Alisa A. Stanford Birthday: 6-16-1958
(First Name, Middle Initial, Last Name)
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Address: 6913 Payson 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>aspirin - 325mg/day</u>	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>2-15-21, 3/18/21, 10/12/21</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.

Alisa A. Stanford Alisa A. Stanford 8/29/22
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>pfizer</u>	<u>FP7137</u>	<u>11/2022</u>	<u>0.3mL IM</u>	<u>(L) Deltoid</u>	<u>8/29/22 1047</u>	<u>unw...</u>

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