



## 2020-2021 COVID-19 Vaccine Consent

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: Michelle Renae Williams-Ward  
(First Name, Middle Initial, Last Name)

Date of Birth: 9-27-75 Social Security Number: \_\_\_\_\_

Phone #: (334) 220-3288 Email: Michelle.Ward953@gmail.com

Patient Address: 2757 Greenoaks Drive Montg. AL 36107  
(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?                                               |     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | <input checked="" type="checkbox"/> |

I have read and understand the 2020-2021 COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS (dated 12/2020). I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine. I have had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Michelle Williams-Ward Michelle Williams-Ward 2-17-21  
(Print Name) (Sign Name) (Date)

### Staff Use Only

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE      | SITE        | DATE/TIME RECEIVED  | Administered By: |
|---------------|---------------|-----------------|-----------------|-------------|---------------------|------------------|
| <u>Pfizer</u> | <u>EN6200</u> | <u>6/21</u>     | <u>0.3ML IM</u> | <u>Left</u> | <u>2/17/21 8:32</u> | <u>L. Smith</u>  |

Next Appointment Date/Time: 03/10/21 0835 0840

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

COVID-19 vaccine. \*\*\*