

Buster



COVID- 19 Vaccine Consent

Name: Adrienne OB Koda Birthday: 2/23/79
(First Name, Middle Initial, Last Name)
Phone #: 334-657-1525 Email: usyka1997@gmail.com
Address: 7239 Greenfield Rd 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?		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>11/12/22</u> ^{10/12/21} <u>date verified.</u>	X	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days? <u>yes</u>		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.

Adrienne Koda [Signature] 12/16/22
(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>GH9702</u>	<u>6/2023</u>	<u>0.3mL Im</u>	<u>left</u>	<u>12/16/22 1115</u>	<u>Siunne</u>

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

vaccine. ***