



## 2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Amy F. Hinton  
(First Name, Middle Initial, Last Name)

Date of Birth: 08/09/1974 Social Security Number: 421043605

Phone #: 334 220 2721 Email: Amyfhinton@icloud.com

Patient Address: 936 Autumn Ridge Rd Mgny, 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?                                     |                                     | <input checked="" type="checkbox"/> |
| 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: <u>Pfizer</u> Date Received: <u>#1: 04/10/2021</u><br><u>#2: 05/01/2021</u>                        |                                     |                                     |
| 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.

Amy F. Hinton [Signature] 10/12/2021  
(Print Name) (Sign Name) (Date)

### Staff Use Only

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE | SITE            | DATE/TIME RECEIVED          | Administered By:             |
|---------------|---------------|-----------------|------------|-----------------|-----------------------------|------------------------------|
| <u>Pfizer</u> | <u>FC3184</u> | <u>10/21</u>    | <u>1m</u>  | <u>(B) delt</u> | <u>2:59</u><br><u>10/12</u> | <u>J Frakes</u><br><u>SN</u> |

Next Appointment Date/Time: \_\_\_\_\_

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

COVID-19 vaccine. \*\*\*