



### 2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Rita F Finlayson  
(First Name, Middle Initial, Last Name)  
Date of Birth: 11/23/1964 Social Security Number: 421-08-6314  
Phone #: 334-303-2609 Email: ritafinlayson@gmail.com  
Patient Address: 2060 Downing St Millbrook, AL 36054  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X  
Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_  
Race: White: X 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?                                     |     | <u>X</u> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | <u>X</u> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | <u>X</u> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | <u>X</u> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | <u>X</u> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | <u>X</u> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |     | <u>X</u> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     |          |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | <u>X</u> |

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.

Rita Finlayson R. Finlayson 2/17/2021  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE   | SITE              | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|--------------|-------------------|--------------------|------------------|
| Pfizer  | EN6200 | 6/21            | 0.3 mL<br>IM | <u>Q1</u><br>Delt | 2/17/21<br>13:14   | D. Bower         |

Next Appointment Date/Time: 3/10/21 1:45pm

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

COVID-19 vaccine. \*\*\*