



2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Kellie L. Johnson
(First Name, Middle Initial, Last Name)
Date of Birth: 1/6/69 Social Security Number: 417213362
Phone #: 5907552 Email: specialk11k@gmail.com
Patient Address: 3329 Horseshoe, Mont AL 36116
(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?		☒
3.) Do you have a bleeding disorder or are on a blood thinner?		☒
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		☒
5.) Do you currently have an acute illness and/or high fever?		☒
6.) Are you immunocompromised or on a medication that affects your immune system?		☒
7.) Have you received another COVID-19 vaccine?		
If Yes, Vaccine Name: <u>Phizer</u> Date Received: <u>2/12 + 3/10 of 21</u>		
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		☒

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.

Kellie Johnson Kellie Johnson 10/12/21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Phizer</u>	<u>F03184</u>	<u>10/31/21</u>	<u>0.5mL IM</u>	<u>(L) deltoid</u>	<u>10/12/21 1514</u>	<u>L. Burton, RN</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. ***