



# 2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: VITALY VOLOSHIN  
(First Name, Middle Initial, Last Name)  
Date of Birth: 03.18.54 Social Security Number: 339-94-8788  
Phone #: 334-808-9385 Email: vvoloshin@troy.edu  
Patient Address: 620 Lawson Dr. Troy, AL 36081  
(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: _____ 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.

VITALY VOLOSHIN V. Voloshin 02.18.21  
(Print Name) (Sign Name) (Date)

## Staff Use Only

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE   | SITE           | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|--------------|----------------|--------------------|------------------|
| Pfizer  | SN6200 | 6/21            | 0.3 mL<br>Im | (L)<br>Deltoid | 2/18/21<br>9:26    | H. Baker         |

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. \*\*\*