



# 2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Katie Donahue  
 (First Name, Middle Initial, Last Name)  
 Date of Birth: 9/15/87 Social Security Number: 419-31-9074  
 Phone #: 3343540544 Email: KatieLDonahue@gmail.com  
 Patient Address: 305 Sydney Dr S. Prattville AL 36066  
 (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.

Katie Donahue [Signature] 2/18/21  
 (Print Name) (Sign Name) (Date)

## -----Staff Use Only-----

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE              | DATE/TIME RECEIVED     | Administered By: |
|---------|--------|-----------------|-------------|-------------------|------------------------|------------------|
| Pfizer  | EN6200 | 6/21            | 0.3mL<br>IM | <u>LT</u><br>Delt | <u>2/18/21</u><br>2:29 | D. Bowen         |

Next Appointment Date/Time: D. Bowen

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