



2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: Carol F. Taylor
(First Name, Middle Initial, Last Name)

Date of Birth: 7-9-1948 Social Security Number: 260 80 5033

Phone #: 334-318-6360 Email: cfTaylor01@bellsouth.net

Patient Address: 1175 Old Ware Rd Wetumpka, AL 36093
(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?		<u>✓</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>✓</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		<u>✓</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		<u>✓</u>
5.) Do you currently have an acute illness and/or high fever?		<u>✓</u>
6.) Are you immunocompromised or on a medication that affects your immune system?		<u>✓</u>
7.) Have you received another COVID-19 vaccine?		<u>✓</u>
If Yes, Vaccine Name: _____ Date Received: _____		<u>✓</u>
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		<u>✓</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.

Carol F. Taylor Carol F. Taylor
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	EW 620	6/2	0.3mL Im	(C) deltoid	2/18/21 759	J Freeman CRN P

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. ***