



COVID- 19 Vaccine Consent

Name: Douglas W. Leaman Birthday: 12-18-1964  
(First Name, Middle Initial, Last Name)  
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Address: 6248 Monticello Cv. Montgomery AL 36117  
(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?                                     |     | X  |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | X  |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | X  |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | X  |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | X  |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | X  |
| 7.) Have you received another COVID-19 vaccine?<br>If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>12-3-2021</u>   | X   |    |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | X  |

I have read and understand the **COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS (Revised 5/2022)**. I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine and had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Douglas W. Leaman [Signature] 11-11-2022  
(Print Name) (Sign Name) (Date)

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

| VACCINE                | LOT #         | EXPIRATION DATE | DOSE/ROUTE      | SITE               | DATE/TIME RECEIVED     | Administered By:         |
|------------------------|---------------|-----------------|-----------------|--------------------|------------------------|--------------------------|
| <u>Pfizer bivalent</u> | <u>GHA702</u> | <u>6/12/23</u>  | <u>0.3mL IM</u> | <u>(B) deltoid</u> | <u>11/11/2022 1330</u> | <u>B. H. H. H. H. H.</u> |

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

vaccine. \*\*\*