



## 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Mark C. Garrison  
(First Name, Middle Initial, Last Name)  
Date of Birth: 03-01-1970 Social Security Number: ### - ## - 1637  
Phone #: 334-799-2800 Email: garrisonm@dot.state.al.us  
Patient Address: 2008 Chancellor Ridge Rd. 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?                                     |                                     | UK                                  |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |                                     | NO                                  |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                                     | NO                                  |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                                     | NA                                  |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                                     | NO                                  |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                                     | NO                                  |
| 7.) Have you received another COVID-19 vaccine?                                                                          | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>4/18/21</u>                                                        |                                     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     | NO                                  |

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.

Mark Garrison

(Print Name)

(Sign Name)

(Date)

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

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE   | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|--------|--------------------|------------------|
| Pfizer  | EW0169 | 8/1             | 3cc<br>IM  | Lt Del | 10/13              | MS Engstrom      |

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. \*\*\***