

Booster- Bivalent



COVID- 19 Vaccine Consent

Name: HERBERT A. MALONEY Birthday: 10-22-48  
 (First Name, Middle Initial, Last Name)  
 Phone #: 334 279-0702 Email: HERBUNC1@aol.com  
 Address: 948 SOMERSET DRIVE 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?                                     |                                     | <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?<br>If Yes, Vaccine Name: <u>PFIZER</u> Date Received: <u>4/29/2022</u>   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| 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 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.

HERBERT MALONEY Herbert A Maloney 9/13/22  
 (Print Name) (Sign Name) (Date)

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

| VACCINE         | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE         | DATE/TIME RECEIVED | Administered By: |
|-----------------|--------|-----------------|-------------|--------------|--------------------|------------------|
| Pfizer Bivalent | GH9702 | 6/30/2023       | 0.3mL<br>IM | L<br>Deltoid | 9/13/22            | Darcram          |

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

vaccine. \*\*\*