



## 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Latasha M. Elsberry (Elsberry)  
(First Name, Middle Initial, Last Name)  
Date of Birth: 9/22/83 Social Security Number: 418-19-7561  
Phone #: (334) 318-6810 Email: latasha.elsberry@yahoo.com  
Patient Address: 7140 Pepper Tree Ln 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?                                                                          |     | <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.

Latasha Elsberry  
(Print Name)

[Signature]  
(Sign Name)

\_\_\_\_\_  
(Date)

### Staff Use Only

| VACCINE | LOT #   | EXPIRATION DATE | DOSE/ROUTE | SITE    | DATE/TIME RECEIVED | Administered By: |
|---------|---------|-----------------|------------|---------|--------------------|------------------|
| Pfizer  | ER 8737 | 7/21            | 0.3ml IM   | RT delt | 4/8/21 8:03        | L. Barton        |

Next Appointment Date/Time: 4/29 @ 8am

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