



2nd



2020-2021 COVID- 19 Vaccine Consent

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

Name of Person Receiving Vaccine: James W. Berry
(First Name, Middle Initial, Last Name)
Date of Birth: 02/09/1959 Social Security Number: 416-92-3244
Phone #: 334-850-1764 Email: dadwesberry@gmail.com
Patient Address: 813 Hillsboro Rd. Montgomery, AL 36109
(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?			☒
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			☒
3.) Do you have a bleeding disorder or are on a blood thinner?			☒
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			☒
5.) Do you currently have an acute illness and/or high fever?			☒
6.) Are you immunocompromised or on a medication that affects your immune system?			☒
7.) Have you received another COVID-19 vaccine? 1st dose If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>04/08/2021</u>		☒	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			☒

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.

James W. Berry James Wesley Berry 04/29/2021
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>EW0169</u>	<u>8/21</u>	<u>0.3 ML IM</u>	<u>(R) Delt.</u>	<u>4/26/21 11:00 AM</u>	<u>J. LEUNER</u>

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. ***