



## 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: James E. Treadway  
(First Name, Middle Initial, Last Name)  
Date of Birth: 08/11/1979 Social Security Number: 421-06-9345  
Phone #: 334-242-6106 Email: TREADWAYJ@DOT.STATE.AL.US  
Patient Address: 92 Kingston Drive Pike Road, AL 36064  
(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: <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?                                |  |                                     | <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.

James E. Treadway [Signature] 04/28/2021  
(Print Name) (Sign Name) (Date)

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

| VACCINE       | LOT #          | EXPIRATION DATE | DOSE/ROUTE     | SITE          | DATE/TIME RECEIVED | Administered By:   |
|---------------|----------------|-----------------|----------------|---------------|--------------------|--------------------|
| <u>Pfizer</u> | <u>EW 0169</u> | <u>8/21</u>     | <u>0.3m Im</u> | <u>lt del</u> | <u>3:37</u>        | <u>[Signature]</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. \*\*\*