



COVID-19 Vaccine Consent

Name: Tim A Gunn (First Name, Middle Initial, Last Name) Birthday: 5-28-1970
Phone #: 334-328-0960 Email: tingunn141@gmail.com
Address: 413 W Pushmataha (Street) Butler AL (City/ State) 36901 (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? If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>12-10-21</u>		☒	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			☒

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.

Tim Gunn (Print Name) Tim Gunn (Sign Name) 7-6-22 (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	Fm 7553	July 31, 2022	0.3mL 1m	④ Deltoid	7/6/22 1502	M. Jai

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

vaccine. ***