

2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: _____

(First Name, Middle Initial, Last Name)

Date of Birth: 6-29-1961Social Security Number: 422-92-4164Phone #: 334-324-8273Email: duffeycarole@hotmail.comPatient Address: 7733 Camberwell

(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?			☒
If Yes, Vaccine Name: _____ Date Received: _____			
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.

Carole Duffey

(Print Name)

(Sign Name)

(Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	2R8737	7/21	0.3ml Im	(L) deltoid	4/9/21 1:58pm	L. Smith

Next Appointment Date/Time: _____

4/30/211:55 pm