



COVID-19 Vaccine Consent

Name: Cynthia L.E. Morris Birthday: 12 August 1951
(First Name, Middle Initial, Last Name)
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(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? <u>22 Nov 2021</u> If Yes, Vaccine Name: <u>Pfizer</u> 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 **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.

Cynthia L.E. Morris [Signature] 22 July 2022
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>pfizer</u>	<u>FM-7553</u>	<u>7/31/22</u>	<u>0.3mL IM</u>	<u>① Deltoid</u>	<u>7/27/22 1340</u>	<u>Richman</u>

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