



COVID- 19 Vaccine Consent

Name: Kathy H Gunn Birthday: 8/26/1971
 (First Name, Middle Initial, Last Name)
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 Address: PO Box 58 Butler AL 36904
 (Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X Ethnicity: Hispanic: _____ Non-Hispanic: _____ Unspecified: _____
 Race: White: _____ African American: X 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?		<u>✓</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>✓</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		<u>✓</u> <u>81mg aspirin</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		<u>✓</u>
5.) Do you currently have an acute illness and/or high fever?		<u>✓</u>
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>Dec 10, 2021</u>	<u>✓</u>	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		<u>✓</u>

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.

Kathy H Gunn [Signature] 7-6-22
 (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 7993</u>	<u>July 31, 2022</u>	<u>0.3mL</u> <u>Im</u>	<u>(L)</u> <u>deltoid</u>	<u>7/6/22</u> <u>1500</u>	<u>M. Fai</u>

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

vaccine. ***