



### 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Keith A. Furr  
(First Name, Middle Initial, Last Name)  
Date of Birth: 5/9/1972 Social Security Number: 419-21-0741  
Phone #: (334) 306-8551 Email: Keithfurr72@gmail.com  
Patient Address: 46 Cedar Hill Rd Ramer AL 36069  
(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: _____ Date Received: _____                                                                         |  |     |                                     |
| 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.

Keith A. Furr Keith A. Furr 4/6/2021  
(Print Name) (Sign Name) (Date)

#### Staff Use Only

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE      | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|-----------|--------------------|------------------|
| Pfizer  | ER8737 | 7/21            | 0.3        | ⊖<br>Delt | 4/9/21<br>1104     | Longham          |

Next Appointment Date/Time: 4/30/21

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

COVID-19 vaccine. \*\*\*