



2020-2021 COVID- 19 Vaccine Consent

Name of Person Receiving Vaccine: MICHAEL W BIRKHEAD
(First Name, Middle Initial, Last Name)

Date of Birth: 5.30.08 Social Security Number:

Phone #: 334-740-9720 Email: _____

Patient Address: 251 FARMINGTON LN PIKE ROAD AC 36064
(Street) (City/ State) (Zip)

Gender: Male: *X* Female:

Ethnicity: Hispanic: _____ Non-Hispanic: 2 Unspecified: _____

Race: White: 7 African American: _____ Asian: _____

American Indian: _____ Native Hawaiian: _____ Other: _____

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.

(Sign Name)

5.11.21

(Date)