



COVID- 19 Vaccine Consent

Name: Shannon E Hargrove Birthday: ~~12/10/05~~ 12/15/05
(First Name, Middle Initial, Last Name)

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Address: 12407 Co Rd 59 Verbena, AL 36091
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X Ethnicity: Hispanic: _____ Non-Hispanic: X 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>X</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>X</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		<u>X</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		<u>X</u>
5.) Do you currently have an acute illness and/or high fever?		<u>X</u>
6.) Are you immunocompromised or on a medication that affects your immune system?		<u>X</u>
7.) Have you received another COVID-19 vaccine? <u>5/21/21 and</u> If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>6/11/21</u>	<u>X</u>	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		<u>X</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.

Shannon Hargrove Shannon Hargrove 8/5/22
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>FP 7137</u>	<u>11/2022</u>	<u>0.3mL</u> <u>1m</u>	<u>(L)</u> <u>Deltoid</u>	<u>8/5/22</u> <u>0950</u>	<u>Bicknell, RN</u>

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

vaccine. ***