

Booster



COVID- 19 Vaccine Consent

Name: Kimberly S. Pyszka Birthday: 7/31/1969  
 (First Name, Middle Initial, Last Name)  
 Phone #: (843) 670-7364 Email: kpyszka@aum.edu  
 Address: 8050 Marylebone Hwy St. #101 Mont AL 36116  
 (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?<br>If Yes, Vaccine Name: <u>✓ 7/1/22</u> Date Received: _____            | <input checked="" type="checkbox"/> |                                     |
| 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 **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.

Kimberly Pyszka K. Pyszka 10/27/2022  
 (Print Name) (Sign Name) (Date)

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

| VACCINE         | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE     | DATE/TIME RECEIVED | Administered By: |
|-----------------|--------|-----------------|-------------|----------|--------------------|------------------|
| Pfizer Bivalent | GH9702 | 6/30/2022       | 0.3ml<br>1m | Left Arm | 10/27/22<br>2:00pm | Deedra M.        |

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

vaccine. \*\*\*