

Booster



COVID-19 Vaccine Consent

Name: Andrew P. CORTELL Birthday: 05/25/1964
(First Name, Middle Initial, Last Name)

Phone #: 334 244 3622 Email: ACORTELL@AUM.EDU

Address: _____
(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?		☒
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		☒
3.) Do you have a bleeding disorder or are on a blood thinner?		☒
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		☒
5.) Do you currently have an acute illness and/or high fever?		☒
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>✓</u> Date Received: <u>6/24/22</u>	☒	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		☒

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.

ANDREW CORTELL ALC 12/13/22
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>pfrizer bivalent</u>	<u>GH9702</u>	<u>6/2023</u>	<u>0.3mL Im</u>	<u>① deltoid</u>	<u>12/13/22 0852</u>	<u>Bicknell</u>

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

vaccine. ***