

Booster- Bivalent



WARHAWK
HEALTH SERVICES

COVID- 19 Vaccine Consent

Name: Pryce L. Haddix Birthday: 3-8-1963
(First Name, Middle Initial, Last Name)

Phone #: 334-244-3333 Email: phaddix@aum.edu

Address: 2042 Commodore Cir. Mgm AL 36106
(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>Pfizer</u> Date Received: <u>6-30-22</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.

Pryce L. Haddix Pryce L. Haddix 9-23-22
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer Bivalent	GH9702	6/30/2023	0.3ml 1m	L reftuid	9/23/22	Daedra M

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

vaccine. ***