



COVID- 19 Vaccine Consent

Name: Kathy W. Jones Birthday: 6/27/55
(First Name, Middle Initial, Last Name)

Phone #: 334-546-0934 Email: Kjones31@aum.edu

Address: 2292 Demaree Dr Millbrook, AL 36054
(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>11/2/21</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.

Kathy W. Jones [Signature] 7/13/22
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	Fm 7593	July 31, 2022	0.3mL Im	Deltoid	7/13/2022 10:30	Bicknell, AN

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