

Booster- Bivalent



WARHAWK
HEALTH SERVICES

COVID- 19 Vaccine Consent

Name: Erin Reilly Birthday: 2/4/1964
(First Name, Middle Initial, Last Name)

Phone #: 334-301-1130 Email: ereilly@aum.edu

Address: 6933 Oak Side Dr Mont AL 36117
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: X 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?		<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? If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>5/27/22</u>	<u>X</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.

Erin Reilly Erin Reilly 10/9/2022
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer Bivalent	GH9702	6/30/2023	0.3ml IM	① Deltoid	10/9/22 1448	RICKHILLER

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

vaccine. ***