

Booster
+



COVID- 19 Vaccine Consent

Name: DAVID M. WALKER Birthday: 5/28/1960
(First Name, Middle Initial, Last Name)

Phone #: 251-366-0029 Email: david.walker@aum.edu

Address: 3928 CROYDON RD. MONTGOMERY AL 36109
(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? <u>3/16 + 4/16/21 (INITIAL DOSE)</u> If Yes, Vaccine Name: <u>MODERNA</u> Date Received: <u>11/14/2021 (BOOSTER)</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.

DAVID M. WALKER [Signature] 6/7/2022
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	Fm 7993	July 31, 2022	0.3ml Im	(1) Deltoid	6/7/2022 10:09	Bicknell

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

vaccine. ***