



**WARHAWK
HEALTH SERVICES**

2020-2021 COVID-19 Vaccine Consent

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: Lois M Cortell
(First Name, Middle Initial, Last Name)

Date of Birth: 9-2-71 Social Security Number: 344-76-0895

Phone #: 334-531-5323 Email: _____

Patient Address: 1343 Woodward MEM AL 36106
(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?		<u>X</u>	
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3-20-21</u>			
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			<u>X</u>

I have read and understand the 2020-2021 COVID-19 VACCINE FACT SHEET FOR RECIPIENTS AND CAREGIVERS (dated 12/2020). I have had the opportunity to discuss the risk/benefits of the COVID-19 vaccine. I have had the chance to ask questions which were answered to my satisfaction. I hereby consent to receive the COVID-19 vaccine.

Lois Cortell Li-Glu 10-28-21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>FC364</u>	<u>10/30/21</u>	<u>0.3mL Im</u>	<u>Lt delt</u>	<u>10/29/21 1118</u>	<u>M. Fairclump</u>

Next Appointment Date/Time: _____

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

COVID-19 vaccine. ***