



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Tracey Bell DOB: 8/12/93 Phone: 214-551-8065

Mailing Address: 811 Legends Dr. City: Montgomery ST: AL Zip: 36110

Insurance Company: BCBS Subscriber name: Tracey Bell DOB: _____

Insurance Contract Number: _____ Group number: _____

Screening Questions: Yes No Don't Know

1) Are you sick today? (cold, fever, acute illness)

☐☒☐

2) Do you have allergies to any foods, medications or latex?

☐☒☐

(For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations)
List _____

3) Have you had any serious reactions from a vaccine?

☐☒☐

4) Have you been diagnosed with Guillain-Barre syndrome?

☐☒☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Tracey Bell Date 10/14/20

Administration Date 10/14/2020 Route: IM (LD or RD) Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 9A235 Expires 06/30/2021

Temp: 99.3