



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: John Harvard DOB: 1/12/79 Phone: 251-680-1870

Mailing Address: 2310 Mitchell Creek Rd. City: Netumpka ST: AL Zip: 36093

Insurance Company: BCBS Subscriber name: _____ 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 _____

Date 9/18/20

Administration Date 9/16/20

Route: IM LD or ID Volume: 0.5cc

Administrator Aprica Howard

VIS Date 08/15/2019

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

Temp: _____