



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Robert Klevay DOB: 12/22/77 Phone: (334) 777-9762

Mailing Address: 3032 Gilman Ave. City: Montgomery ST: AL Zip: 36105

Insurance Company: BCBS Subscriber name: Robert Klevay DOB: 12/22/77

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 [Signature] Date Sept 5, 2023

Administration Date 9/5/2023 Route: IM (LD) or RD Volume: 0.5ml

Administrator L. Barton, CRNP VIS Date 08/06/2021

Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024

Temp: 96.8

