



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Natasha Colvin DOB: 4/24/79 Phone: 334-244-3883

Mailing Address: _____ City: _____ ST: _____ Zip: _____

Insurance Company: BCBS Subscriber name: Natasha Colvin DOB: _____

Insurance Contract Number: QA0869846783 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 <u>penicillin</u> | ☒ | ☐ | ☐ |
| 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 Natasha Colvin Date 9/28/20

Administration Date 09/28/2020 Route: IM (LD) or RD Volume: 0.5cc

Administrator Jayrica Harvard VIS Date 08/15/2019

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

Temp: 97.5