



**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: SHEILA M. AUSTIN  
(First Name, Middle Initial, Last Name)

Date of Birth: 03/18/52 Social Security Number: 292-50/2527

Phone #: 334-294-0097 Email: Saustin1@aum.edu

Patient Address: 3757 Hyde Ln. Montg, AL 36106  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ Unspecified: \_\_\_\_\_

Race: White: \_\_\_\_\_ African American: X 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?                                                                          |     |          |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3/5/21</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.

SHEILA AUSTIN [Signature] 10/12/21

(Print Name)

(Sign Name)

(Date)