



**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: Claudio Stein
(First Name, Middle Initial, Last Name)
Date of Birth: 1/4/1974 Social Security Number: 604-75-6044
Phone #: 314-6808822 Email: cstein1@aum.edu
Patient Address: 4 Carrie House Lane Pikes Road, AL 36064
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X
Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____
Race: White: X African American: _____ 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?	<u>X</u>	
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3/18/21</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.

Claudio Stein [Signature] 11/19/21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>F03184</u>	<u>11/2022</u>	<u>0.3ml 1m</u>	<u>(L) deltoid</u>	<u>11/19/21 1925</u>	<u>Fain, CNP</u>

Next Appointment Date/Time: _____

*****If you present to the Emergency Department for any treatment, please inform the staff you have received the**

COVID-19 vaccine. ***