



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Robert Bullard DOB: 7/23/91 Phone: 334 3139035

Mailing Address: 2032 Merritt Dr. City: Montgomery ST: AL Zip: 36111

Insurance Company: BCBS AL Subscriber name: _____ DOB: 7/23/91

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 Robert Bullard Date 10/22/20

Administration Date 10/22/20 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

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

Temp: 98.8

