



**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: Katherine L. Slade
(First Name, Middle Initial, Last Name)
Date of Birth: 2/14/1982 Social Security Number: 258-41-0327
Phone #: (706) 585-6119 Email: kslade@aum.edu
Patient Address: 92033 Lochfield Dr. Pike 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>2/12/21; 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.

Katherine Slade Katherine Slade 10/12/21
(Print Name) (Sign Name) (Date)

-----Staff Use Only-----

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	FC3184	10/21	0.3mL / IM	Right arm deltoid	10/12/21 3:57pm	Hollyann Oarden Student Nurse

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. ***