



**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: Richard Fleming  
(First Name, Middle Initial, Last Name)

Date of Birth: 2-13-73 Social Security Number: 422-19-7397

Phone #: 334-399-6913 Email: hydroclean@aatt.net

Patient Address: 2023 Red Hawk Rd. Prattville, AL 36067  
(Street) (City/ State) (Zip)

**Please Check One:**

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

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?                                     |          |          |
| 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>3-2-22</u>                                                         | <u>X</u> |          |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |          | <u>X</u> |

*Don't know*

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.

Richard Fleming  
(Print Name)

[Signature]  
(Sign Name)

4-14-2022  
(Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE         | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|-------------|--------------|--------------------|------------------|
| Pfizer  | FJU369 | 5/2022          | 0.3mL<br>1m | Ⓢ<br>Deltoid | 4/14/22<br>0910    | Bicknell, RN     |

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. \*\*\*