



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Danielle Taylor DOB: 11-09-01 Phone: (334)-717-4752

Mailing Address: 720 Maryethel Dr. City: MGM ST: AL Zip: 36109

Insurance Company: BCBS Subscriber name: _____ DOB: _____

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 <u>peanuts</u>	☒	☐	☐
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 Danielle Taylor Date 9/8/23

Administration Date 9/8/2023 Route: IM LD or RD Volume: 0.5ml

Administrator M. Bicknell, RN VIS Date 08/06/2021

Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024

Temp: 97.7



514456



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Taylor

FIRST NAME: Danielle

TSCC ID #: A02318443

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: 9/8/23 MANUFACTURER: GSK LOT #: G2ML4 EXPIRATION DATE: 6/30/24

SITE OF INJECTION: ☐ LEFT DELTOID ☒ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: M. Bicknell CREDENTIALS OF PERSON ADMINISTERING: PN

SIGNATURE OF PERSON ADMINISTERING: [Signature] PN

NAME OF OFFICE OR FACILITY: AUM WHS PHONE #: (334) 244-3281

STREET ADDRESS: 7461 East Dr. CITY: Montgomery STATE: AL ZIP CODE: 36117
Suite 102

Provider:
Please place office stamp
here (if possible) for
validation purposes.

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