



**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: James D. Francisco

(First Name, Middle Initial, Last Name)

Date of Birth: 08/31/1980

Social Security Number: 409-35-1577

Phone #: 512-413-4647

Email: jfranci2@aum.edu

Patient Address: 1941 S. Hill St Montgomery, AL 36117

(Street)

(City/State)

(Zip)

Please Check One:

Gender: Male: ☒ Female: ☐

Ethnicity: Hispanic: ☐ Non-Hispanic: ☒ Unspecified: ☐

Race: White: ☒ 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?

3.) Do you have a bleeding disorder or are on a blood thinner?

4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)

5.) Do you currently have an acute illness and/or high fever?

6.) Are you immunocompromised or on a medication that affects your immune system?

7.) Have you received another COVID-19 vaccine?

If Yes, Vaccine Name: Pfizer Date Received: 2/12/21

8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?

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.

James D. Francisco

(Print Name)

James D. Francisco

(Sign Name)

3/5/21

(Date)