



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: Gilbert Duenas
(First Name, Middle Initial, Last Name)

Date of Birth: 3-25-55 Social Security Number: 546-02-3674

Phone #: 334-301-2880 Email: gilberto.duenas2010@gmail.com

Patient Address: 7600 Preservation Park Dr. Montg 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?		X
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		X
3.) Do you have a bleeding disorder or are on a blood thinner?		X
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		X
5.) Do you currently have an acute illness and/or high fever? <u>Osteoporosis</u>		
6.) Are you immunocompromised or on a medication that affects your immune system? <u>High blood pressure</u>	X	X
7.) Have you received another COVID-19 vaccine?		
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2-12-21</u>	X	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		X

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.

Gilbert Duenas Gilbert Duenas Mar. 5, 2021
(Print Name) (Sign Name) (Date)