



**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 S. Howard
(First Name, Middle Initial, Last Name)

Date of Birth: 12/20/74 Social Security Number: 419-17-1667

Phone #: 251 510-5732 Email: khowar2@aum.edu

Patient Address: 3612 McRae Loop Montgomery, AL 36116
(Street) Apt F (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?		no
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		no
3.) Do you have a bleeding disorder or are on a blood thinner?		no
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		no
5.) Do you currently have an acute illness and/or high fever?		no
6.) Are you immunocompromised or on a medication that affects your immune system?		no
7.) Have you received another COVID-19 vaccine?		
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2/12/21</u>	yes	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		no

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 S. Howard K S Howard 3/5/21
(Print Name) (Sign Name) (Date)