



**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: David S. Feltmate  
(First Name, Middle Initial, Last Name)  
Date of Birth: 09/27/81 Social Security Number: 392-61-1859  
Phone #: 334-306-9867 Email: dfeltmat@aum.edu  
Patient Address: 5062 Crawford Fitzpatrick/A 36029  
(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?                                     |                                     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |                                     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                                     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                                     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                                     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                                     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          | <input checked="" type="checkbox"/> |                                     |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3/05/21</u>                                                        |                                     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     | <input checked="" type="checkbox"/> |

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.

David Feltmate David Feltmate 12/13/21  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE           | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|-------------|----------------|--------------------|------------------|
| Pfizer  | FL3184 | 12/2022         | 0.3ml<br>1m | (L)<br>deltoid | 12/13/21<br>1500   | Rickman          |

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. \*\*\*