



**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: Rachel E. Jones-Pincumbe
(First Name, Middle Initial, Last Name)

Date of Birth: 07/29/1981 Social Security Number: 409-51-9288

Phone #: 334 300 2842 Email: rjones27@aum.edu

Patient Address: 75 Travertine Dr. Pike Road AL 36064
(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? <u>Allergic to coriander & cilantro</u>		X
2.) Have you ever had a life-threatening allergic reaction to any vaccine? <u>Had a severe reaction to the pneumonia vaccine in Jan. 2019 -</u>		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?		X
6.) Are you immunocompromised or on a medication that affects your immune system?		X
7.) Have you received another COVID-19 vaccine?		X
If Yes, Vaccine Name: _____ Date Received: _____		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.

Rachel E. Jones-Pincumbe R E J-P 02/12/2021
(Print Name) (Sign Name) (Date)
Pfizer EM6200 6/11 0.3 mL (B) 2/12/2021 (Date) Freeman
Delt 0727