



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Peter Zachar DOB: 8-10-83 Phone: 3311

Mailing Address: 8424 March Pond Dr City: UGA ST: GA Zip: 30607

Insurance Company: BCBS Subscriber name: _____ DOB: _____

Insurance Contract Number: _____ Group number: _____

Screening Questions: Yes No Don't Know

1) Are you sick today? (cold, fever, acute illness) ☐ ☒ ☐

2) Do you have allergies to any foods, medications or latex? ☐ ☒ ☐

(For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations)

List _____

3) Have you had any serious reactions from a vaccine? ☐ ☒ ☐

4) Have you been diagnosed with Guillain-Barre syndrome? ☐ ☒ ☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Peter Zachar Date 9-19-22

Administration Date 9/19/2022 Route: IM LD or RD Volume: 0.5ml

Administrator m. Bicknell, RN VIS Date 08/15/2019

Manufacturer: GSK Fluorix® Quadrivalent Lot # M3R5B Expires 06/30/2023

Temp: 98.4

