



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: Susan M. Decker-Bunce
(First Name, Middle Initial, Last Name)

Date of Birth: 1-16-88 Social Security Number: 8004

Phone #: 334-399-1080 Email: sdeckerb@aum.edu

Patient Address: 2059 S. Lincoln Terrace Montgomery AL 36108
(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?		☒
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		☒
3.) Do you have a bleeding disorder or are on a blood thinner?		☒
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		☒
5.) Do you currently have an acute illness and/or high fever?		☒
6.) Are you immunocompromised or on a medication that affects your immune system?		☒
7.) Have you received another COVID-19 vaccine?		☒
If Yes, Vaccine Name: _____ Date Received: _____		
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		☒

Multicasone +
Azelastine
Nasal Spray

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.

Susan Decker-Bunce Susan Decker-Bunce 2/15/21

(Print Name)

(Sign Name)

(Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	EN6200	6/21	0.3 ml IM	L Arm	2/15 7:33	<u>[Signature]</u>

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. ***