



**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: DARLENE A ADKINS
(First Name, Middle Initial, Last Name)
Date of Birth: May 6, 1965 Social Security Number: 223908378
Phone #: 2408936111 Email: DADKINS3@aum.edu
Patient Address: 1838 Young Farm Rd Montgomery, AL 36106
(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: <u>Pfizer</u> Date Received: <u>3/8/21</u>		
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		☒

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.

DARLENE ADKINS Darlene Adkins 10/12/21
(Print Name) (Sign Name) (Date)

-----Staff Use Only-----

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>pfizer</u>	<u>#C3184</u>	<u>10/21</u>	<u>1m</u>	<u>@Pelt</u>	<u>10/12</u> <u>2:56</u>	<u>J Frakes</u> <u>SN</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. ***