



**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: Randall J Smith

(First Name, Middle Initial, Last Name)

Date of Birth: 4-8-1962

Social Security Number: 417 92 4739

Phone #: 334-403 2005

Email: Zimbelstern 62@gmail.com

Patient Address: 2 B Calhoun Rd Mont

(Street)

(City/ State)

(Zip) 36109

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?

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.

Randall J Smith

(Print Name)

Randall J Smith

(Sign Name)

3-8-21

(Date)