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: Tamara J Massey - Garrett
(First Name, Middle Initial, Last Name)

Date of Birth: 8/17/62 Social Security Number: 690-62-8811

Phone #: 334-559-1513 Email: tmassey2@aum.edu

Patient Address: 3518 Dalraida Pkwy, Montgomery, AL 36109
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: X 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?		X
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?		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? If Yes, Vaccine Name: ~~Pfizer 1st dose~~ Date Received: ~~2/15/21~~		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.

Tamara J Massey - Garrett Tamara J Massey-Garrett 3/8/21
(Print Name) (Sign Name) (Date)