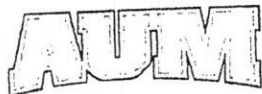


Pfizer
booster



**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: ROBERT INGRAM
(First Name, Middle Initial, Last Name)
Date of Birth: 12/5/69 Social Security Number: 416-21-2051
Phone #: 334 221-6849 Email: RJIngram1@gmail.com
Patient Address: 2244 CARTER ROAD MontA 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>3/10/21</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.

Robert Ingram [Signature] 1/6/21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>FC31M</u>	<u>01/30/22</u>	<u>0.3ml IM</u>	<u>① deltoid</u>	<u>11/07/2021 1427</u>	<u>Bismellian</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. ***