



**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: Virginia E Hill
(First Name, Middle Initial, Last Name)

Date of Birth: 10-29-47 Social Security Number: 042-44-1324

Phone #: 334-262-8019 Email:

Patient Address: 508 Castlebrook Dr Montgomery AL 36110-1618
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: Female: L

Ethnicity: Hispanic: Non-Hispanic: Unspecified:

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

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.

Virginia E Hill Virginia E Hill 3-10-2021
(Print Name) (Sign Name) (Date)