



**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: William R. Lemaster Jr.
(First Name, Middle Initial, Last Name)

Date of Birth: 03/14/03 Social Security Number: 425 313 360

Phone #: 334 233 4442 Email: bill@evangelchurch.me

Patient Address: 7500 Fairway Dr Montgomery AL 36116
(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>2/17/21</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.

William Lemaster

(Print Name)

[Signature]

(Sign Name)

3/10/21

(Date)