



**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: Cristina B LeMaster  
(First Name, Middle Initial, Last Name)

Date of Birth: 08-03-1993 Social Security Number: 783 38-1780

Phone #: (334) 354-5585 Email: cristina.leMaster@gmail.com

Patient Address: 131 Silver Pointe Dr Elmore 36025  
(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?                                     |  |                                     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |  |                                     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |  |                                     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |  |                                     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |  |                                     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |  |                                     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |  | <input checked="" type="checkbox"/> |                                     |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>Feb-17-2021</u>                                                    |  |                                     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |  |                                     | <input checked="" type="checkbox"/> |

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.

Cristina LeMaster

(Print Name)

CLeMaster

(Sign Name)

3-10-2021

(Date)