



**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: Heidi G Mense  
(First Name, Middle Initial, Last Name)

Date of Birth: 6/12/1982 Social Security Number: 536-08-5797

Phone #: 334 324 7288 Email: heidi.mense@gmail.com

Patient Address: 87 Stone Park Trl Pike Road 36064  
(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: _____ Date Received: _____                                                                         |  |     | <input checked="" type="checkbox"/> |
| 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.

Heidi Mense Heidi Mense 2/17/2021  
(Print Name) (Sign Name) (Date)

**-----Staff Use Only-----**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|-------------|------|--------------------|------------------|
| Pfizer  | EN6200 | 6/31            | 0.3mL<br>IM | Rt   | 2/17/21<br>11:50AM | J Leuner         |

Next Appointment Date/Time: 3/10/21 @ 3:15pm

**\*\*\*If you present to the Emergency Department for any treatment, please inform the staff you have received the**

**COVID-19 vaccine. \*\*\***