



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: Hayd Conner

(First Name, Middle Initial, Last Name)

Date of Birth: 1-16-65

Social Security Number: 417131041

Phone #: 3343721199

Email: HaydConner40@gmail.com

Patient Address: 160 McPherson Dr

(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: _____ Date Received: _____		
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.

Hayd Conner

(Print Name)

Hayd Conner

(Sign Name)

2-17-21

(Date)