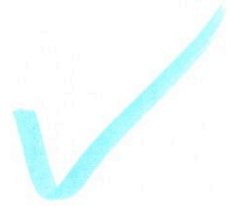




WARHAWK HEALTH SERVICES

2020-2021 COVID- 19 Vaccine Consent



Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: JOHNNY L. PAULK
(First Name, Middle Initial, Last Name)

Date of Birth: 03/01/57 Social Security Number: 423-82-1631

Phone #: 334-430-3983 Email: johnny.paulk@ipaper.com

Patient Address: P.O. Box 134 FT. DEPOSIT AL 36032
(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.

JOHNNY PAULK

(Print Name)

Johnny Paulk

(Sign Name)

2/17/21

(Date)