



**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: Barbara A. Harper  
(First Name, Middle Initial, Last Name)

Date of Birth: 3/14/59 Social Security Number: 111-50-3884

Phone #: 334-318-9268 Email: grammy2698@yahoo.com

Patient Address: 4840 Alamo Dr Mont Al 36116  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_

Race: White: \_\_\_\_\_ African American: X 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?                                     |                       | <u>X</u>                        |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |                       | <u>X</u>                        |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                       | <u>X</u>                        |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                       | <u>X</u>                        |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                       | <u>X</u>                        |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                       | <u>X</u>                        |
| 7.) Have you received another COVID-19 vaccine?                                                                          | <u>BP</u><br><u>X</u> | <u>error</u><br><del>XXXX</del> |
| 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?                                |                       | <u>X</u>                        |

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.

Barbara A. Harper BAH 3/14/21  
(Print Name) (Sign Name) (Date)