



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: Christopher S Clark

(First Name, Middle Initial, Last Name)

Date of Birth: 11/20/92 Social Security Number: 417-41-0308

Phone #: 334-782-9214 Email: mosiercharlotte@gmail.com

Patient Address: 6640 Heritage Oak MGN, AL 36117

(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: <u>Pfizer</u> Date Received: <u>Feb 17th</u>		/	
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.

Chris Clark

(Print Name)

Chris Clark

(Sign Name)

3-10-21

(Date)