



**WARHAWK
HEALTH SERVICES**

2020-2021 COVID-19 Vaccine Consent

Instructions: Fill out the Warhawk Health Services COVID-19 Vaccine Consent. Please Print Legibly.

Name of Person Receiving Vaccine: Mary R. Hallman (Katie)
(First Name, Middle Initial, Last Name)

Date of Birth: 6-01-1976 Social Security Number: 419-29-7350

Phone #: 334-398-1074 Email: katie.hallman@acboe.net

Patient Address: 1372 Co. Rd. 85 Prattville, AL 36067
(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:

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? (We'll need written approval from OB/GYN prior to receiving vaccine)

☒

5. Do you currently have an acute illness 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 antibody 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.

Mary R. Hallman

(Print Name)

Mary R. Hallman

(Sign Name)

2-17-2020

(Date)