



**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: Marilyn R. Shirey
(First Name, Middle Initial, Last Name)

Date of Birth: 11/24/35 Social Security Number: 196-26-8578

Phone #: (251) 656-6581 Email: none

Patient Address: 2012 Home Park Trail #110 36066
(Street) (City/ State) Prattville, AL (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? <u>not received any vaccines since childhood</u>		☒
3.) Do you have a bleeding disorder or are <u>on a blood thinner</u> <u>on Plavix (not sure of name)</u>		☒
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? <u>1st Covid shot</u>	☒	
If Yes, Vaccine Name: _____ Date Received: <u>2/17/21</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.

MARILYN R SHIREY

(Print Name)

Marilyn R. Shirey

(Sign Name)

3/10/21

(Date)