



**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:

Coretha W Gould

(First Name, Middle Initial, Last Name)

Date of Birth:

8/19/76

Social Security Number:

418-13-2295

Phone #:

(334) 354-0822

Email:

CorethaJay@aol.com

Patient Address:

558 Virginia Ave Montgomery AL

(Street)

(City/ State)

36104

(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:

Pfizer

Date Received:

2-17-21

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.

Coretha W Gould

(Print Name)

Coretha W Gould

(Sign Name)

3/10/2021

(Date)