



**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:

Janet Arrighi Moseley
(First Name, Middle Initial, Last Name)

Date of Birth:

2/25/1971

Social Security Number:

Phone #:

(334) 300-9986

Email:

janet.moseley@mps.k12.al.us

Patient Address:

805 Franklin Rd MHA
(Street) (City/ State)

36105
(Zip)

Please Check One:

Gender:

Male: _____

Female: X

Ethnicity:

Hispanic: _____

Non-Hispanic: _____

Unspecified: X

Race: White: X

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?

X

2.) Have you ever had a life-threatening allergic reaction to any vaccine?

X

3.) Do you have a bleeding disorder or are on a blood thinner?

X

4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)

X

5.) Do you currently have an acute illness and/or high fever?

X

6.) Are you immunocompromised or on a medication that affects your immune system?

X

7.) Have you received another COVID-19 vaccine?

If Yes, Vaccine Name:

Pfizer

Date Received:

2/18/21

X

8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?

X

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.

Jan Moseley
(Print Name)

[Signature]
(Sign Name)

3/11/2021
(Date)