



**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:

Odeia J. Williams
(First Name, Middle Initial, Last Name)

Date of Birth:

04-23-81

Social Security Number:

602-07-5824

Phone #:

334-398-1561

Email:

dashin22002@yahoo

Patient Address:

212 Cornell Rd
(Street)

Montgomery AL 36109
(City/ State)

(Zip)

Please Check One:

Gender:

Male:

Female:

X

Ethnicity:

Hispanic:

Non-Hispanic:

Unspecified:

X

Race: White:

African American:

Asian:

X

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?

X

If Yes, Vaccine Name:

Date Received:

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.

Odeia J. Williams

(Print Name)

[Signature]

(Sign Name)

2-18-21

(Date)