



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: Odella J. Williams
(First Name, Middle Initial, Last Name)

Date of Birth: 04-23-81 Social Security Number: 612-07-5824

Phone #: 334-398-1561 Email: clashina22000@yahoo

Patient Address: 212 Cornell Rd Montgomery AL 36109
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: 1 Female: X

Ethnicity: Hispanic: Non-Hispanic: X Unspecified:

Race: White: African American: X 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?	X	
If Yes, Vaccine Name: <u>Fizer</u> Date Received: <u>2-18-21</u>		
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.

Odella Williams Odella Williams 3-11-21
(Print Name) (Sign Name) (Date)