



**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:

Shawanda D. Dullman

(First Name, Middle Initial, Last Name)

Date of Birth:

01-25-76

Social Security Number:

419-27-8091

Phone #:

334 303-4994

Email:

sdullman1@gmail.com

Patient Address:

4100 Marine Hall Trail Brady AL 36036

(Street)

(City/ State)

(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:

Date Received:

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.

Shawanda Dullman

(Print Name)

Shawanda Dullman

(Sign Name)

2/18/21

(Date)