



**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:

Godfrey W Shepherd

(First Name, Middle Initial, Last Name)

Date of Birth:

7/30/1959

Social Security Number:

422-82-1778

Phone #:

334-430-10310

Email:

Shepherd Godfrey A @ COL

Patient Address:

1231 Boyd Road

(Street)

Shafter Ala

(City/ State)

34875

(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.

Godfrey W Shepherd

(Print Name)

[Signature]

(Sign Name)

2/18/2021

(Date)