



**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:

Paula S. Crowell
(First Name, Middle Initial, Last Name)

Date of Birth:

8/23/57

Social Security Number:

424-82-4820

Phone #:

334-301-7770

Email:

paulacrowell@gmail.com

Patient Address:

16 Blantwood Montgomery
(Street) (City/ State)

AL 36109
(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.

Paula S. Crowell

(Print Name)

Paula S. Crowell

(Sign Name)

2/18/21

(Date)