



**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: _____

Carla P. Anderson

(First Name, Middle Initial, Last Name)

Date of Birth: _____

4/5/61

Social Security Number: _____

421-98-5228

Phone #: _____

334-590-0624

Email: _____

dsl1982@icloud.com

Patient Address: _____

232 Joyce St

Prattville, AL

36066

(Street)

(City/ State)

(Zip)

Please Check One:

Gender:

Male: _____

Female: _____

X

Ethnicity:

Hispanic: _____

Non-Hispanic: _____

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?		<u>X</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>X</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		<u>X</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		<u>X</u>
5.) Do you currently have an acute illness and/or high fever?		<u>X</u>
6.) Are you immunocompromised or on a medication that affects your immune system?		<u>X</u>
7.) Have you received another COVID-19 vaccine?		<u>X</u>
If Yes, Vaccine Name: _____ Date Received: _____		<u>X</u>
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		<u>X</u>

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.

Carla Anderson Carla Anderson

(Print Name)

(Sign Name)

2/18/21

(Date)