



**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: Jennifer Shae Campbell Slay
(First Name, Middle Initial, Last Name)

Date of Birth: 8/15/1975 Social Security Number: 421-02-9316

Phone #: 334-546-9312 Email: scslay75@gmail.com (shae.slay@acba.net)
^{work}

Patient Address: 800 Ryefield Rd Montgomery AL 36117
(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?		NO
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		NO ☒
5.) Do you currently have an acute illness and/or high fever?		NO
6.) Are you immunocompromised or on a medication that affects your immune system?		NO
7.) Have you received another COVID-19 vaccine?		NO
If Yes, Vaccine Name: _____ Date Received: _____		NO
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		NA

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.

Shae Campbell Slay Shae Campbell Slay 2/18/2021
(Print Name) (Sign Name) (Date)