



**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: ATANU K GUHA
(First Name, Middle Initial, Last Name)

Date of Birth: 3/22/1963 Social Security Number:

Phone #: 334-313-4092 Email: atanu-guha@hotmail.com

Patient Address: 1430 Hallwood Ln Montg 36117
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male Female:

Ethnicity: Hispanic: Non-Hispanic: Unspecified: Asian

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)		NA
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: <u> </u> Date Received: <u> </u>		✓
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.

ATANU GUHA
(Print Name)

Ah [Signature]
(Sign Name)

2/18/2021
(Date)