



**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 L Hartzell

(First Name, Middle Initial, Last Name)

Date of Birth: 12/31/69

Social Security Number: 424-21-3554

Phone #: 205 381 8071

Email: jhartzell@montevallo.edu

Patient Address: 1610 Sweet Apple Ct B'ham, AL 35242

(Street)

(City/ State)

(Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: X 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?

X

2.) Have you ever had a life-threatening allergic reaction to any vaccine?

X

3.) Do you have a bleeding disorder or are on a blood thinner?

X

4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)

X

5.) Do you currently have an acute illness and/or high fever?

X

6.) Are you immunocompromised or on a medication that affects your immune system?

X

7.) Have you received another COVID-19 vaccine?

If Yes, Vaccine Name: Pfizer Date Received: 2/18/21

8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?

X

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.

Jennifer Hartzell

(Print Name)

[Signature]

(Sign Name)

3/11/21

(Date)