



**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: Leslie Meadows

(First Name, Middle Initial, Last Name)

Date of Birth: 2-18-70

Social Security Number: 419-23-3776

Phone #: 334-462-6142

Email: lmeadows@aum.edu

Patient Address: 1106 Arrowhead Rd.

(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?			☒
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: <u>Pfizer</u> Date Received: <u>2/3/21</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.

Leslie Meadows

(Print Name)

[Signature]

(Sign Name)

10-29-21

(Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>FL 3184</u>	<u>10/30/21</u>	<u>0.3mL 1m</u>	<u>① Deltoid</u>	<u>10/29/21 1415</u>	<u>R. HUNTER</u>

Next Appointment Date/Time: _____

*****If you present to the Emergency Department for any treatment, please inform the staff you have received the**

COVID-19 vaccine. ***