



**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: Thomas, W, Abbott  
(First Name, Middle Initial, Last Name)

Date of Birth: 06/14/1970 Social Security Number: 417-04-8748

Phone #: 205-871-6585 Email: tabbott1@montevallo.edu

Patient Address: 152 Cedar Cove Drive Pelham 35124  
(Street) (City/ State) (Zip)

**Please Check One:**

**Gender:** Male: X Female: \_\_\_\_\_

**Ethnicity:** Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ Unspecified: X

**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?                                     |     | No |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | No |
| 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?                                |     | No |

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.

Thomas W. Abbott

(Print Name)

(Sign Name)

02-17-2021

(Date)

**Staff Use Only**

| VACCINE       | LOT #        | EXPIRATION DATE | DOSE/ROUTE    | SITE               | DATE/TIME RECEIVED  | Administered By:               |
|---------------|--------------|-----------------|---------------|--------------------|---------------------|--------------------------------|
| <u>Phizer</u> | <u>EN600</u> | <u>6/21</u>     | <u>0.3 ml</u> | <u>(R) deltoid</u> | <u>2/18/21 145P</u> | <u>Abbott</u><br><u>Nguyen</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. \*\*\***