



**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: Brooke E. Johnson  
(First Name, Middle Initial, Last Name)

Date of Birth: 04-09-2000 Social Security Number:                     

Phone #: 727-463-0658 Email: bejohn11@aum.edu

Patient Address: 160 N Ross St apt 123B Ahwan 38630  
(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?                                                                          |     | X  |
| 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?                                |     | 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.

Brooke Johnson Brooke Johnson 2/18/20  
(Print Name) (Sign Name) (Date)