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: Duwan U. Walker
(First Name, Middle Initial, Last Name)

Date of Birth: 10/09/73 Social Security Number: 254-73-8516

Phone #: 251-327-0507 Email: duwan@walkerenterprisesllc.com

Patient Address: 110 Jordan Crossing Prattville AL 36067
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: X Female: _____

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

Race: White: _____ African American: X 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: 02/18/21	X	
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.

Dawan Walker [signature] 03/11/21
(Print Name) (Sign Name) (Date)