



**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:

Carmen Moore-Zeigler
(First Name, Middle Initial, Last Name)

Date of Birth:

5-15-72

Social Security Number:

419-25-5867

Phone #:

251 223-7281

Email:

Carmen@moorezeiglergroup.com

Patient Address:

4040 Valencia Dr Montgomery AL
(Street) (City/State)

36116
(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: _____ Date Received: _____

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.

Carmen Moore Zeigler

(Print Name)

Chris

(Sign Name)

Feb 18, 2021

(Date)