



# 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: Zandra Y Toney  
(First Name, Middle Initial, Last Name)

Date of Birth: 5-29-1970 Social Security Number: 419-21-1812

Phone #: 334-220-9795 Email: Zytoney@gmail.com

Patient Address: 3921 McCain Ln Montgomery AL 36106  
(Street) (City/State) (Zip)

### Please Check One:

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

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ 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?                                     |  |          | <u>X</u> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |  |          | <u>X</u> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |  |          | <u>X</u> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |  |          | <u>X</u> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |  |          | <u>X</u> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |  |          | <u>X</u> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |  |          |          |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2-26-21</u>                                                        |  | <u>X</u> |          |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |  |          | <u>X</u> |

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.

Zandra Y. Toney Zandra Toney 3-19-21  
(Print Name) (Sign Name) (Date)

### Staff Use Only

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE      | SITE       | DATE/TIME RECEIVED | Administered By: |
|---------------|---------------|-----------------|-----------------|------------|--------------------|------------------|
| <u>Pfizer</u> | <u>E06205</u> | <u>6/21</u>     | <u>0.5ml IM</u> | <u>(L)</u> | <u>3/19/21</u>     | <u>Howard</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. \*\*\***