



**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: Reuben Earl Buice Jr  
(First Name, Middle Initial, Last Name)  
Date of Birth: 4-22-58 Social Security Number: 418 82 5065  
Phone #: 334 750 5120 Email: rbuice77@gmail.com  
Patient Address: 12 Dixie Circle Tallahassee AL 36078  
(Street) (City/ State) (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?                                     |                                     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |                                     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                                     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                                     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                                     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                                     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |                                     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: <u>PFIZER</u> Date Received: <u>2-26-21</u>                                                        | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     | <input checked="" type="checkbox"/> |

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.

Reuben Buice Reuben Buice 3-19-21  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE      | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|-----------|--------------------|------------------|
| Pfizer  | EN6205 | 6/21            | 0.3 mL     | Ⓛ<br>Delt | 3/19/21<br>853     | Morris           |

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. \*\*\***