



**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: STEVE F. BAILEY
(First Name, Middle Initial, Last Name)

Date of Birth: 10-14-1957 Social Security Number: 418-90-6692

Phone #: 334-221-6953 Email: SBAILEY@MONTGOMERYAL.GOV

Patient Address: 4091 County Rd 37 FITZPATRICK 36029
(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?			NO
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			NO
3.) Do you have a bleeding disorder or are on a blood thinner?			NO
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			NO
5.) Do you currently have an acute illness and/or high fever?			NO
6.) Are you immunocompromised or on a medication that affects your immune system?			NO
7.) Have you received another COVID-19 vaccine?			NO
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2/24/21</u>		Yes	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			NO

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.

STEVE F. BAILEY Steve F. Bailey 3/19/21
(Print Name) (Sign Name) (Date)