



**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: Nichole M Davis  
(First Name, Middle Initial, Last Name)

Date of Birth: 4.15.72 Social Security Number: 409 53 9151

Phone #: 334 430 744 Email: nichole.davis@aeboe.net

Patient Address: 1014 Longfield Dr Prattville AL 36067  
(Street) (City/ State) (Zip)

**Please Check One:**

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

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_

Race: White: X 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?                                     |          | <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?                                                                          | <u>X</u> |          |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2.26.21</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.

Nichole Davis Nichole Davis 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>EN6205</u> | <u>6/21</u>     | <u>0.3 mL</u> | <u>①</u><br><u>DT</u> | <u>3/19/21</u><br><u>842</u> | <u>Morris</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. \*\*\***