



**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: Valerie Allen-Porterheco
(First Name, Middle Initial, Last Name)

Date of Birth: 6/19/70 Social Security Number: 132-56-4474

Phone #: 3343000729 Email: allenva⁹⁹⁰⁰lerie@aol.com

Patient Address: 6813 Buvar Gate CT Montgomery AL 36116
(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?		☒
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: <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?		☒

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.

Valerie Allen-Porterheco [Signature] 3/19/21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
pf. zer	EN6205	6/21	0.3 mL IM	(Lt) delt	3/19/21 10:12	D. Bowen

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. ***