



**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: Deborah A Colvin
(First Name, Middle Initial, Last Name)

Date of Birth: 4-11-56

Social Security Number: 416-82-0329

Phone #: 205-532-6194

Email: DeborahColvin39@gmail.com

Patient Address: 246 Chancellor Pidges RD (Street)
Prattville, AL (City/State)
36066 (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: ☒ 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.

Deborah Colvin

(Print Name)

Deborah Colvin

(Sign Name)

03-19-21

(Date)