



**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: Ava E Howard
(First Name, Middle Initial, Last Name)

Date of Birth: 04/12/2007 Social Security Number: _____

Phone #: (334) 462-2115 Email: drshoward@yahoo.com

Patient Address: 2813 South Colonial Montgomery, AL 36111
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: _____ African American: X 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: _____ Date Received: _____		
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.

Stephanie Howard Stephanie R Howard
(Print Name) (Sign Name)

04/13/2021
(Date)