



# 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: MAURICE J. GOODE  
(First Name, Middle Initial, Last Name)

Date of Birth: 8-21-61 Social Security Number: \_\_\_\_\_

Phone #: 334-262-1592 Email: \_\_\_\_\_

Patient Address: 4259 BOUTWELL DR. MOBILE, AL. 36616  
(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?                                     |                                     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |                                     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |                                     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |                                     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |                                     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |                                     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |                                     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: <u>PFIZER</u> Date Received: <u>2-26-21</u>                                                        | <input checked="" type="checkbox"/> |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     | <input checked="" type="checkbox"/> |

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.

MAURICE J. GOODE M. J. Goode 3-19-21  
(Print Name) (Sign Name) (Date)

### -----Staff Use Only-----

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE      | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|-----------|--------------------|------------------|
| Pfizer  | EN6205 | 6/21            | 1m<br>0.3m | L<br>Delt | 3/19/21<br>11:13   | NEOLVIN          |

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. \*\*\*