



**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 W Treece Jr.
(First Name, Middle Initial, Last Name)

Date of Birth: 10/12/1955 Social Security Number: 418-64-7839

Phone #: 334-207-5311 Email: MW.TREECE@AOL.COM

Patient Address: 500 Towne Lake Drive Montgomery, AL 36117
(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?		No
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		No
3.) Do you have a bleeding disorder or are on a blood thinner?		No
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		NA
5.) Do you currently have an acute illness and/or high fever?		No
6.) Are you immunocompromised or on a medication that affects your immune system?		No
7.) Have you received another COVID-19 vaccine?		No
If Yes, Vaccine Name: _____ Date Received: _____		No
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		No

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 Wayne Treece Jr. Maurice W Treece Jr. 1/26/2021
(Print Name) (Sign Name) (Date)