



**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: Kareshia J. Grant
(First Name, Middle Initial, Last Name)

Date of Birth: 08-19-1990 Social Security Number: 423-35-3951

Phone #: 334-380-1743 Email: mSk920@gmail.com

Patient Address: 227 Roth Street Prattville, AL 36067
(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?		N/A
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		N/A
3.) Do you have a bleeding disorder or are on a blood thinner?		N/A
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		no
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?		N/A
7.) Have you received another COVID-19 vaccine? <u>yes</u>	☒	
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2-26-20</u>		
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.

Kareshia J. Grant Kareshia J. Grant 03/19/2021
(Print Name) (Sign Name) (Date)