



**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: Soon Lee  
(First Name, Middle Initial, Last Name)

Date of Birth: 2/10/62 Social Security Number: 344849079

Phone #: 334 782 0108 Email: \_\_\_\_\_

Patient Address: 5901 Sanrock Terrace Dr Montgomery, AL 36116  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ Unspecified: \_\_\_\_\_

Race: White: \_\_\_\_\_ African American: \_\_\_\_\_ Asian: X

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?<br><u>high - cholesterol</u>           | <u>X</u> |     |          |
| 7.) Have you received another COVID-19 vaccine?                                                                          |          |     |          |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2/26/21</u>                                                        | <u>X</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.

Lee Soon

(Print Name)

Soon Lee

(Sign Name)

3/19/21

(Date)

**-----Staff Use Only-----**

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE                | SITE                    | DATE/TIME RECEIVED             | Administered By: |
|---------------|---------------|-----------------|---------------------------|-------------------------|--------------------------------|------------------|
| <u>Pfizer</u> | <u>EN6205</u> | <u>6/21</u>     | <u>1m</u><br><u>0.3ml</u> | <u>L</u><br><u>Delt</u> | <u>3/19/21</u><br><u>10:40</u> | <u>N Colvin</u>  |

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. \*\*\***