



**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: Terrel Lynn Houston  
(First Name, Middle Initial, Last Name)

Date of Birth: 4 Nov 2021 Social Security Number: 465-31-5819

Phone #: 334-324-4169 Email: tangoagatha@hotmail.com

Patient Address: 2106 St. Charles Ave Montgomery, AL 36107  
(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?<br>If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>3/19/2021</u>   | <input checked="" type="checkbox"/> |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     |                                     |

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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.

Terrel Lynn Houston Terrel Lynn Houston 19 Nov 2021  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE      | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|-------------|-----------|--------------------|------------------|
| Pfizer  | FL3184 | 1/2022          | 0.3ml<br>1m | ① deltoid | 11/19/21<br>1440   | Bartini, LNP     |

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. \*\*\*