



**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: Charlotte R. Hosea  
(First Name, Middle Initial, Last Name)  
Date of Birth: 8/10/1965 Social Security Number: 423-90-4954  
Phone #: (334) 239-6093 Email: hoseac@dot.state.al.us  
Patient Address: 3445 Wickham Road Montgomery, AL 36116  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X  
Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_  
Race: White: \_\_\_\_\_ African American: X 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?                                     |     | X            |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | X            |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | X            |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | X            |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | X            |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | X            |
| 7.) Have you received another COVID-19 vaccine?                                                                          | X   | <del>X</del> |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>4/8/21</u>                                                         |     |              |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | X            |

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.

Charlotte R. Hosea

(Print Name)

Charlotte R. Hosea

(Sign Name)

04/27/2021

(Date)

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

| VACCINE | LOT #   | EXPIRATION DATE | DOSE/ROUTE | SITE    | DATE/TIME RECEIVED | Administered By: |
|---------|---------|-----------------|------------|---------|--------------------|------------------|
| Pfizer  | EW 0169 | 8/21            | 0.3ml IM   | Lt Delt | 4/29/21 8:02       | D. Marzette      |

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. \*\*\***