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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: Ricarda Parrish
(First Name, Middle Initial, Last Name)

Date of Birth: 6/12/90 Social Security Number: 589 898108

Phone #: 334467 7421 Email: ricardaparrish@gmail.com

Patient Address: 514 Melanie Dr. MOBILE 36609
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: X African American: _____ Asian: _____

American Indian: _____ Native Hawaiian: _____ Other: German

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?	<u>X</u>	
7.) Have you received another COVID-19 vaccine?		
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>4/8/21</u>	<u>X</u>	
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		<u>X</u>

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.

Ricarda Parrish

(Print Name)

[Signature]

(Sign Name)

29/APR/21

(Date)