



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: Chris Lee Ryan (Ryan)
(First Name, Middle Initial, Last Name)

Date of Birth: 7-10-79 Social Security Number: 420-08-7195

Phone #: 334-300-7228 Email: _____

Patient Address: 42 Hillside North 36025
(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?		<u>/</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>/</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		<u>/</u>
5.) Do you currently have an acute illness and/or high fever?		<u>/</u>
6.) Are you immunocompromised or on a medication that affects your immune system?		<u>/</u>
7.) Have you received another COVID-19 vaccine?		<u>/</u>
If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>4/6/21</u>	<u>/</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.

Chris Ryan [Signature] 4-29-21
(Print Name) (Sign Name) (Date)