



**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: Willie Pearl Flowers  
(First Name, Middle Initial, Last Name)  
Date of Birth: 2/7/1954 Social Security Number: 420-74-9819  
Phone #: (334) 669-5485 Email: pflowers2@hotmail.com  
Patient Address: 3013 Sutton Dr. Montg. 36111  
(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?                                                                          |                                     |                                     |
| If Yes, Vaccine Name: <u>Pfizer</u> Date Received: _____                                                                 | <input checked="" type="checkbox"/> |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |                                     | <input checked="" type="checkbox"/> |

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.

Willie Pearl Flowers Willie Pearl Flowers 10/29/2021  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE       | DATE/TIME RECEIVED | Administered By:   |
|---------|--------|-----------------|-------------|------------|--------------------|--------------------|
| Pfizer  | FC3184 | 10/30/21        | 0.3mL<br>IM | Lt deltoid | 10/29/21<br>2:55pm | M. J. Fain<br>CRNP |

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. \*\*\***