



**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: Sharon B Windham
(First Name, Middle Initial, Last Name)

Date of Birth: 12/2/69 Social Security Number: 4221576602

Phone #: 505-270-5826 Email: gowindham@aol.com

Patient Address: 714 Wyntakes Rd. Mont. AL 36117
(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?			☒
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			☒
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)			☒
5.) Do you currently have an acute illness and/or high fever?			☒
6.) Are you immunocompromised or on a medication that affects your immune system?		☒	☒
7.) Have you received another COVID-19 vaccine?		☒	
If Yes, Vaccine Name: <u>Pfizer 1st dose</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?			☒

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.

Sharon Windham Sharon Windham 4/29/21

(Print Name)

(Sign Name)

(Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	EW0169	8/21	0.3 mL IM	② Delt.	4/29/21 10:11 AM	J. LEVNER

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. ***