

2nd Jose



**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: Alexis N Bryant
(First Name, Middle Initial, Last Name)

Date of Birth: 03-09-1984 Social Security Number: 417-19-1585

Phone #: 384-300-4541 Email: anshell84@gmail.com

Patient Address: 136 Walnut Point Dr Wetumpka AL 36093
(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?		<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?	<u>X</u>	
If Yes, Vaccine Name: <u>pfizer</u> Date Received: <u>4/9/2021</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.

Alexis Bryant
(Print Name)

Alexis Bryt
(Sign Name)

4/30/2021
(Date)