



**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: Justin Turner  
(First Name, Middle Initial, Last Name)

Date of Birth: 11/20/00 Social Security Number: 424-51-1175

Phone #: 334-758-5555 Email: joanont6@gmail.com

Patient Address: 2041 Briar Gate Dr. Monty, AL 36116  
(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 type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           | <input type="checkbox"/> | <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 type="checkbox"/> | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |                          |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                | <input type="checkbox"/> | <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.

Justin Turner Justin Turner 4/7/21  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE   | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|--------|--------------------|------------------|
| Pfizer  | ER8737 | 7/21            | .3 mL      | 2 Delt | 4/8/21<br>3:34     | Stewart          |

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. \*\*\*