



**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: Lisa E. Washington
(First Name, Middle Initial, Last Name)

Date of Birth: 9/1/66 Social Security Number: 421- -5040

Phone #: 334 669-1692 Email: lw8144@att.com

Patient Address: 2348 W. Aberdeen Dr. Montgomery 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?		✓
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> </u> Date Received: <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.

Lisa Washington Lisa Washington 4/8/21
(Print Name) (Sign Name) (Date)