



**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: Tonisha S. Gallimore
(First Name, Middle Initial, Last Name)

Date of Birth: 12/05/1993 Social Security Number: 043-92-03506

Phone #: (334) 439-9321 Email: nishagallimore@gmail.com

Patient Address: 1403 Mount Pleasant Rd. Clanton, AL 35045
(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? * PENICILLIN ALLERGY *	☒		
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: _____ Date Received: _____			
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.

Tonisha Gallimore Tonisha Gallimore 4/30/21
(Print Name) (Sign Name) (Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
PF.2cr	EW 0169	8/21	0.3	Left Deltoid	4/30/21 1:06 pm	L. Barton

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. *****