



**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:

Kelley Maltby
(First Name, Middle Initial, Last Name)

Date of Birth:

3-23-69

Social Security Number:

25

Phone #:

452-5151

Email:

pinklampshade323@yahoo.com

Patient Address:

409 Woodhaven Lane
(Street)

Wetumpka AL
(City/ State)

36093
(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:

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.

Kelley Maltby
(Print Name)

(Sign Name)

(Date)

Kelley Maltby 4-8-21