



**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: Jada K Player
(First Name, Middle Initial, Last Name)

Date of Birth: 5-20-04 Social Security Number: 420572274

Phone #: 334-202-8225 Email: Kimplayer2@hotmail.com

Patient Address: 27 Lake Park Dr. Pike Road AL 36064
(Street) (City/State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: _____ 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: _____ Date Received: _____			
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.

Jada Player

(Print Name)

Jada Player

(Sign Name)

4/8/21

(Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	ER8732	7/21	.3mL	L delt	4/8/21 3:42	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. ***