



**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: Joshua H. Tobias  
(First Name, Middle Initial, Last Name)

Date of Birth: 12/19/2002 Social Security Number: 393 23 5973

Phone #: (949)303-6607 Email: MUHAMMAD5@GMAIL.COM

Patient Address: 9753 Silver Bell Ct Pike Road AL 36064  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: X Female: \_\_\_\_\_

Ethnicity: Hispanic: X Non-Hispanic: \_\_\_\_\_ Unspecified: \_\_\_\_\_

Race: White: X 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?                                     |     | <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: _____                                                                         |     | <u>X</u> |
| 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.

Joshua Tobias 4/9/2021  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE      | SITE          | DATE/TIME RECEIVED  | Administered By: |
|---------------|---------------|-----------------|-----------------|---------------|---------------------|------------------|
| <u>Pfizer</u> | <u>EP8732</u> | <u>7/21</u>     | <u>0.3mL IM</u> | <u>Ⓛ Delt</u> | <u>4-9-21 12:58</u> | <u>S. Howard</u> |

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. \*\*\***