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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: Rachel M. Riccell
(First Name, Middle Initial, Last Name)

Date of Birth: 10/12/1958 Social Security Number: 025-52-0925

Phone #: 334-546-2493 Email: rwestwareham@aum.edu.com

Patient Address: 3331 Arborfield Rd Montgomery 36107
(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?			<u>_____</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			<u>_____</u>
3.) Do you have a bleeding disorder or are on a blood thinner?			<u>_____</u>
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			<u>_____</u>
5.) Do you currently have an acute illness and/or high fever?		<u>_____</u>	
6.) Are you immunocompromised or on a medication that affects your immune system?			<u>_____</u>
7.) Have you received another COVID-19 vaccine?			
If Yes, Vaccine Name: <u>Bizer</u> Date Received: <u>4/8/21</u>			
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			<u>_____</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.

Rachel M. Riccell Rachel M. Riccell 4/29/21
(Print Name) (Sign Name) (Date)