



**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: Amanda H Williford
(First Name, Middle Initial, Last Name)

Date of Birth: 01/23/1996 Social Security Number: 418-45-5509

Phone #: 334-294-9440 Email: Amandawilliford21@gmail.com

Patient Address: 3844 Fawnsdale Dr Montgomery, AL 36109
(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?		✓
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.

Amanda Hope Williford

(Print Name)

Amanda Williford

(Sign Name)

04-09-2021

(Date)