AUM
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: Kelvin Alonzo Johnson
(First Name, Middle Initial, Last Name)

Date of Birth: 09-21-1979 Social Security Number: 420-17-0167

Phone #: 334 315 2685 Email: Kelvinajohnson@Aol.com

Patient Address: 2152 E Aberdeen Dr (Street) Montgomery AL (City/ State) 36116 (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: Pfizer Date Received: 4/9/21		✓ ✓
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.

Kelvin Johnson (Print Name) _____ (Sign Name) 4/29/21 (Date)