



**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: Kelly A. Hoerner
(First Name, Middle Initial, Last Name)

Date of Birth: 01-03-1961 Social Security Number: 546-29-8987

Phone #: 925 768 5567 Email: KELLYSMALLBOX@GMAIL.COM

Patient Address: 1829 WINDSOR TOWNS CT. MONTGOMERY AL 36117
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X 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>✓</u>
7.) Have you received another COVID-19 vaccine?			<u>✓</u>
If Yes, Vaccine Name: _____ Date Received: _____			<u>✓</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.

Kelly Hoerner
(Print Name)

[Signature]
(Sign Name)

April 8 2021
(Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>2R8737</u>	<u>7/21</u>	<u>0.3ml Im</u>	<u>(R) deltoid</u>	<u>4/8/21 0846</u>	<u>R. Wheat</u>

Next Appointment Date/Time: 4/29/21 @ 8:50 am

***If you present to the Emergency Department for any treatment, please inform the staff you have received the

COVID-19 vaccine. ***