



**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: Stacey B. Yeend  
(First Name, Middle Initial, Last Name)  
Date of Birth: 1-13-67 Social Security Number: 408-04-8757  
Phone #: 334-531-8366 Email: stacey@aroma.com  
Patient Address: 536 Lynnhurst Ct Mont., AL 36117  
(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?                                     |     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     | <input checked="" type="checkbox"/> |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | <input checked="" type="checkbox"/> |

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.

Stacey B. Yeend Stacey B Yeend 4/9/21  
(Print Name) (Sign Name) (Date)

**Staff Use Only**

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE   | SITE      | DATE/TIME RECEIVED             | Administered By:  |
|---------------|---------------|-----------------|--------------|-----------|--------------------------------|-------------------|
| <u>Pfizer</u> | <u>ER8737</u> | <u>7/21</u>     | <u>0.3mL</u> | <u>LT</u> | <u>4/9/21</u><br><u>3:48pm</u> | <u>C. Stewart</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. \*\*\***