



**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: Rasheeda D. Boykin
(First Name, Middle Initial, Last Name)

Date of Birth: 12/26/90 Social Security Number: 481-19-5785

Phone #: 600-9292 Email: rasheedboykin@gmail.com

Patient Address: 400 Fieldbrook Dr. Montgomery 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?			☒
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.

Rasheeda Boykin R. W. B. 4/30/21
(Print Name) (Sign Name) (Date)