

2nd
dose



**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: Mohammad Y Alshamir
(First Name, Middle Initial, Last Name)

Date of Birth: 5/10/1966 Social Security Number: 323-98-2324

Phone #: 773 988 4520 Email: Mikealshamir@hotmail.com

Patient Address: 7425 MillRidge Montgomery 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: <u>Pfizer</u> Date Received: <u>4/9/21</u>	☒	☐
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.

Mohammad Alshamir

(Print Name)

MC

(Sign Name)

4/30/2021

(Date)