

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: Pedro Pablo Tapia
(First Name, Middle Initial, Last Name)

Date of Birth: 3/19/97 Social Security Number: _____

Phone #: 334 201 6372 Email: Pedro Tapia.1010@gmail.com

Patient Address: 3388 MCGEE AVE APT D Montgomery AL 36116
(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.

Pedro Pablo Tapia

(Print Name)

[Signature]

(Sign Name)

4/30/21

(Date)