



**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: Sandra G. Johnson  
(First Name, Middle Initial, Last Name)  
Date of Birth: 4/13/1962 Social Security Number: 423-94 0808  
Phone #: 304 1202-2986 Email: jsal6@uphaw.com  
Patient Address: 7355 Bogey Beaumont, AL 36616  
(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"/> | <input checked="" type="checkbox"/> |
| 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?                                |  |                                     | <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.

Sandra G. Johnson

(Print Name)

(Sign Name)

(Date)

**-----Staff Use Only-----**

| VACCINE       | LOT #         | EXPIRATION DATE | DOSE/ROUTE    | SITE         | DATE/TIME RECEIVED | Administered By:   |
|---------------|---------------|-----------------|---------------|--------------|--------------------|--------------------|
| <u>Pfizer</u> | <u>EW0169</u> | <u>8/21</u>     | <u>0.3 IM</u> | <u>RtDel</u> | <u>3/2/21</u>      | <u>[Signature]</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. \*\*\***