



**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: JEFF E. MARSH  
(First Name, Middle Initial, Last Name)

Date of Birth: 4-7-69 Social Security Number: 419-15-2801

Phone #: 242-6629 Email: MARSHJE@dot.state.AL.US

Patient Address: 409 CAPITAL PKWY. CT. 36107  
(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.

JEFF MARSH  
(Print Name)

[Signature]  
(Sign Name)

4-8-21  
(Date)

**Staff Use Only**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE | DATE/TIME RECEIVED | Administered By:  |
|---------|--------|-----------------|------------|------|--------------------|-------------------|
| Pfizer  | EQ9F37 | 7/21            | 0.3ml      | LT   | 12:37<br>4/9/21    | Dr.<br>C. Stewart |

Next Appointment Date/Time: 4/30 @ 12:35pm

**\*\*\*If you present to the Emergency Department for any treatment, please inform the staff you have received the**

**COVID-19 vaccine. \*\*\***