

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: Saeed Schwaib  
(First Name, Middle Initial, Last Name)

Date of Birth: Oct. 8, 1990 Social Security Number: \_\_\_\_\_

Phone #: 334 517 5573 Email: S.Schwaib22@gmail.com

Patient Address: 601 Taylor Oaks Cir 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?                                     |     | <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: _____                                                                         |     |                                     |
| 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.

Saeed Schwaib

(Print Name)

[Signature]

(Sign Name)

4/30/21

(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>NADEL</u> | <u>12:56</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. \*\*\*