



# 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: Marianna F. Houston  
(First Name, Middle Initial, Last Name)

Date of Birth: 02/01/1993 Social Security Number: 373-15-705

Phone #: (586) 350-7644 Email: houston.marianna23@gmail.com

Patient Address: 5844 Brewster Blvd 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: _____                                                                         |  |     | <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.

Marianna Houston

(Print Name)

Marianna Houston

(Sign Name)

04/09/21

(Date)