

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: Joe Phillips
(First Name, Middle Initial, Last Name)

Date of Birth: 4/30/51 Social Security Number: 421-74-0327

Phone #: 334-833-5676 Email: Joe Phillips 1954 yahoo.com

Patient Address: 600 Tysonville Rd Shoter 36075
(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? <i>Sinus</i>	☒	☐
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)	☐	<i>NA</i>
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.

Joe Phillips Joe Phillips 4/30/51
(Print Name) (Sign Name) (Date)