



**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: Lashanda L Smith
(First Name, Middle Initial, Last Name)

Date of Birth: April 15, 1971 Social Security Number: _____

Phone #: (334) 233-6536 Email: lashandasmith2@yahoo.com

Patient Address: 119 Nature's Trail Wetumpka, AL 36093
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X
Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____
Race: White: _____ African American: X 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?			☒
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? <u>Low Dose Bayer Aspirin (81 mg once a day)</u>	☒		
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			☒
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.

Lashanda L Smith Lashanda L Smith 4/9/21
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Pfizer</u>	<u>2R87357</u>	<u>7/21</u>	<u>0.3ml</u> <u>Im</u>	<u>(L)</u> <u>deltoid</u>	<u>4/9/21</u> <u>8:16</u>	<u>Wheat</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. ***