



# 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: Tranisha LAQuantis Chapman  
(First Name, Middle Initial, Last Name)

Date of Birth: 03/20/2000 Social Security Number: 414-51-4657

Phone #: (334) 202-0070 Email: tranisha.chapman5@gmail.com

Patient Address: 11113 Handey Road Montgomery 36117  
(Street) (City/ State) (Zip)

### Please Check One:

Gender: Male: \_\_\_\_\_ Female: X

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: \_\_\_\_\_ 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?                                     |  |     | <u>X</u> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |  |     | <u>X</u> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |  |     | <u>X</u> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |  |     | <u>X</u> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |  |     | <u>X</u> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |  |     | <u>X</u> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |  |     | <u>X</u> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |  |     |          |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |  |     | <u>X</u> |

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.

Tranisha Chapman Tranisha Chapman 04/01/2021  
(Print Name) (Sign Name) (Date)