



**WARHAWK
HEALTH SERVICES**

2020-2021 COVID- 19 Vaccine Consent

Rescheduled
for April 29th
@ 7:55

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Remove
4/30
appt.

Name of Person Receiving Vaccine: Joseph J Masarik
(First Name, Middle Initial, Last Name)

Date of Birth: 11/22/1968 Social Security Number: 510 80 054

Phone #: 334 782 3172 Email: jmasarik@aum.edu

Patient Address: 1255 Bell Rd Deatsville AL 36022
(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?			☒
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)			NA
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.

Masarik, Joseph
(Print Name)

[Signature]
(Sign Name)

9 April 2021
(Date)