



**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: Lori Y Johnson
(First Name, Middle Initial, Last Name)

Date of Birth: 9-25-74 Social Security Number: 422 196325

Phone #: 205 907 8348 Email: lorijohnson88@hotmail.com

Patient Address: 1408 Canterbury Lane Mobile AL 36604
(Street) (City/ State) (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X Unspecified: _____

Race: White: X 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)			
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.

Lori Johnson

(Print Name)

Lori Johnson

(Sign Name)

4-10-21

(Date)