



**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: Kathy H Gunn
(First Name, Middle Initial, Last Name)
Date of Birth: 8/26/71 Social Security Number: 4210
Phone #: 334-313-4009 Email: Kgunn1989@gmail.com
Patient Address: 6504 Ashford Circle Montg AL 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: <u>Pfizer</u> Date Received: <u>4/9 + 4/30/21</u>			
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			<u>X</u>

81mg aspirin
Havent
taken in
week
or more

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.

Kathy H Gunn Kathy H Gunn 12/10/21
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
Pfizer	F63184	11/2022	0.3mL 1m	(R) deltoid	12/10/22 1035	Bicknell

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. ***