



**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: Michael J. Thomas
(First Name, Middle Initial, Last Name)

Date of Birth: 6-28-63 Social Security Number: 419-06-7770

Phone #: 334-220-7724 Email: monthoma@aol.com

Patient Address: 8100 Talon Ct. Montgomery, AL 36117
(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?			NONE I'm aware of
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: <u>Pfizer</u> Date Received: <u>4-30-21</u>			
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.

Michael J. Thomas

(Print Name)

M. J. Thomas

(Sign Name)

6-11-21

(Date)