



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: Stephanie O. Smith
(First Name, Middle Initial, Last Name)

Date of Birth: 06-29-1967 Social Security Number: 419-98-5993

Phone #: 334.224.1964 Email: SSmith5717@gmail.com

Patient Address: 5717 Worcester St. Mt Pleasant 36116
(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?		<u>X</u>
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		<u>✓</u>
3.) Do you have a bleeding disorder or are on a blood thinner?		<u>✓</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?		
If Yes, Vaccine Name: <u>PFizer</u> Date Received: <u>5-11-21</u>		
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.

Stephanie O. Smith
(Print Name)

SS
(Sign Name)

6/11/2021
(Date)