

2nd


**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: Anil Kumar Reddy
 (First Name, Middle Initial, Last Name)

 Date of Birth: 8-16-1997 Social Security Number: _____

 Phone #: _____ Email: anilreddymofficial@gmail.com

 Patient Address: Fairhaven-8275 Barrington-Montgomery 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?			☒
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.

_____ Anil Reddy _____ 7-2-2021
 (Print Name) (Sign Name) (Date)