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: Aerielle M. Sanford
(First Name, Middle Initial, Last Name)

Date of Birth: 08-29-2001 Social Security Number: 420-53-4846

Phone #: 334-235-3128 Email: aerielle.sanford@icloud.com

Patient Address: 97 Hoffman Road (Street) Lapine/AL (City/ State) 36046 (Zip)

Please Check One:

Gender: Male: _____ Female: X

Ethnicity: Hispanic: _____ Non-Hispanic: X 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?		X
2.) Have you ever had a life-threatening allergic reaction to any vaccine?		X
3.) Do you have a bleeding disorder or are on a blood thinner?		X
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)		X
5.) Do you currently have an acute illness and/or high fever?		X
6.) Are you immunocompromised or on a medication that affects your immune system?		X
7.) Have you received another COVID-19 vaccine? If Yes, Vaccine Name: _____ Date Received: _____		X
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?		X

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.

Aerielle Sanford (Print Name) Aerielle Sanford (Sign Name) 7/2/2021 (Date)