



WARHAWK HEALTH SERVICES

2020-2021 COVID-19 Vaccine Consent

Aalaysia

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: Aalaysia Z Vines
(First Name, Middle Initial, Last Name)

Date of Birth: September 14, 1994 Social Security Number: 418439255

Phone #: 334-233-6831 Email: aalaysiavines@yahoo.com

Patient Address: P.O. Box 242914 Montgomery, AL 36124
(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?			No
2.) Have you ever had a life-threatening allergic reaction to any vaccine?			No
3.) Do you have a bleeding disorder or are on a blood thinner?			No
4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine)			No
5.) Do you currently have an acute illness and/or high fever?			No
6.) Are you immunocompromised or on a medication that affects your immune system?			No
7.) Have you received another COVID-19 vaccine?			No
If Yes, Vaccine Name: _____ Date Received: _____			No
8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?			No

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.

Aalaysia Vines Aalaysia Vines 4/8/21
(Print Name) (Sign Name) (Date)

4/29 7:50