



**WARHAWK  
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Beckett Barton DOB: 12/30/14 Phone: (334) 714-7186

Mailing Address: 2020 Red Hawk Rd City: Prattville ST: Al. Zip: 36067

Insurance Company: BCBS Subscriber name: Dustin Barton DOB: 5/30/75

Insurance Contract Number: \_\_\_\_\_ Group number: \_\_\_\_\_

Screening Questions:

- |                                                                                                                                                                    | Yes                      | No                                  | Don't Know               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| 1) Are you sick today? ( cold, fever, acute illness)                                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2) Do you have allergies to any foods, medications or latex?<br>(For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations)<br>List _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3) Have you had any serious reactions from a vaccine?                                                                                                              | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you been diagnosed with Guillain-Barre syndrome?                                                                                                           | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature

J. Barton

Date

10/11/21

Administration Date

10/11/21

Route: IM

LD or

RD

Volume: 0.5cc

Administrator

M. Bicknell, RN

VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 7R9NM Expires 06/30/2022

Temp:

98.1