



**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: ELENA CIESIELSKA  
(First Name, Middle Initial, Last Name)

Date of Birth: 11/23/1994 Social Security Number: /

Phone #: 334 450 9873 Email: egciesielscy@gmail.com

Patient Address: 7072 Peppertree Lane Montgomery, AL 36117  
(Street) (City/ State) (Zip)

**Please Check One:**

Gender: Male: \_\_\_\_\_ Female: X

Ethnicity: Hispanic: \_\_\_\_\_ Non-Hispanic: X Unspecified: \_\_\_\_\_

Race: White: X 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>X</u> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | <u>X</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?                                                                          |     | <u>X</u> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     |          |
| 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.

ELENA CIESIELSKA Elena Ciesielska 8/11/2021  
(Print Name) (Sign Name) (Date)

**-----Staff Use Only-----**

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE  | SITE | DATE/TIME RECEIVED  | Administered By: |
|---------|--------|-----------------|-------------|------|---------------------|------------------|
| pfizer  | EW0169 | 8/31/21         | 0.3ml<br>IM | LT   | 8/11/21<br>12:56 PM | Jean Leumes      |

Next Appointment Date/Time: 8-31-21 @ 1pm

**\*\*\*If you present to the Emergency Department for any treatment, please inform the staff you have received the**

**COVID-19 vaccine. \*\*\***