



**WARHAWK  
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Leanna Michele Phillips DOB: 3-28-69 Phone: 334-790-4974

Mailing Address: 6513 Gloucester Meadows City: Montgomery ST: AL Zip: 36117

Insurance Company: BCBS Subscriber name: \_\_\_\_\_ DOB: \_\_\_\_\_

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 <u>PCN</u> | <input checked="" type="checkbox"/> | <input 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 Michelle Phillips Date 11-2-23

Administration Date 11/2/2023 Route: IM LD or RD Volume: 0.5ml

Administrator M. Bicknell RN VIS Date 08/06/2021

Manufacturer: GSK Fluarix® Quadrivalent Lot # G2ML4 Expires 06/30/2024

Temp: 97.7



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