



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: Karalynne C Matthews

(First Name, Middle Initial, Last Name)

Date of Birth: Jan 19, 2002

Social Security Number: 423-53-0755

Phone #: 334-430-4782

Email: Karalynnem5673@gmail.com

Patient Address: 6610 E Cypress Ct

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

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.

Karalynne Matthews

(Print Name)

(Sign Name)

(Date)

9/8/21