



**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: Kathryn J. Clark  
(First Name, Middle Initial, Last Name)

Date of Birth: 2-23-85 Social Security Number: \_\_\_\_\_

Phone #: 334 288 5072 Email: espanol/fan@gmail.com

Patient Address: 2559 Churchill Drive Montgomery, AL 36111  
(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?                                           |     | Not Known |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?<br><u>Never had Pertussis vaccine</u>               |     | ✓         |
| 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?<br>If Yes, Vaccine Name: <u>Pfizer</u> Date Received: <u>2/9/21 and 3/2/21</u> | ✓   |           |
| 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.

Kathryn J. Clark

(Print Name)

Kathryn J. Clark

(Sign Name)

10-12-21

(Date)