



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Pryce L. Haddix DOB: 3-8-1963 Phone: 334-244-3333

Mailing Address: 2042 Commodore Circle City: Mgm ST: AL Zip: 36106

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)

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2) Do you have allergies to any foods, medications or latex?

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(For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations)

List _____

3) Have you had any serious reactions from a vaccine?

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4) Have you been diagnosed with Guillain-Barre syndrome?

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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: Pryce L. Haddix Date: 9-23-22

Administration Date: 9/23/22 Route: IM LD or RD Volume: 0.5ml

Administrator: Daedra M VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # M3R5B Expires 06/30/2023

Temp: 97.8