

Buster



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: LESTER A. SLITER
(First Name, Middle Initial, Last Name)

Date of Birth: 10/9/1944

Social Security Number: 264-74-5864

Phone #: 334-396-4300

Email: go-gators@charter.net

Patient Address: 8094 Ansley Trace MGM 36117
(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: <u>Moderna</u> Date Received: <u>8/11/2021</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.

LESTER SLITER Lester Sliter 8/11/2021
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Moderna</u>	<u>020F21A</u>	<u>1/22/22</u>	<u>0.25 mL</u>	<u>Lf delt</u>	<u>11/3/21 1:11pm</u>	<u>M. Jancino</u>

Next Appointment Date/Time: _____

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

COVID-19 vaccine. ***