



**WARHAWK
HEALTH SERVICES**

3rd dose ✓

2020-2021 COVID-19 Vaccine Consent

Instructions: Complete and present prior to vaccine administration. (Please Print Legibly).

Name of Person Receiving Vaccine: James Kyle Taylor
(First Name, Middle Initial, Last Name)

Date of Birth: 5/3/1969 Social Security Number: _____

Phone #: 244 3606 Email: jtaylor@aum.edu

Patient Address: 7736 Steele Ridge Dr Mt 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>3/10/21</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.

Kyle Taylor
(Print Name)

KJT
(Sign Name)

10/25/2021
(Date)

Staff Use Only

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:
<u>Moderna</u>	<u>020F21A</u>	<u>01/21/22</u>	<u>0.25mL</u> <u>Im</u>	<u>Left deltoid</u>	<u>10/25/21</u> <u>1409</u>	<u>M. Fain</u> <u>CRNP</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. ***