



**WARHAWK
HEALTH SERVICES**

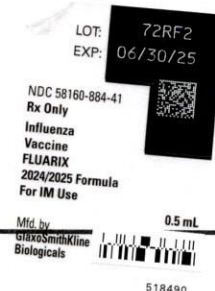
Vaccine Consent and Administration Record

Name: Debra Tomblin DOB: 7/16/57 Phone: X 3250
Room 103 Administration
Mailing Address: Bldg, AUM City: Montg ST: AL Zip: 36036117
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)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations) List _____	☐	☒	☐
3) Have you had any serious reactions from a vaccine?	☐	☒	☐
4) Have you been diagnosed with Guillain-Barre syndrome?	☐	☒	☐

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 Debra Y Tomblin Date 8/29/2024
Administration Date 8/29/2024 Route: IM LD or RD Volume: 0.5ml
Administrator M. Bicknell, RN VIS Date 08/06/2021
Manufacturer: GSK Fluarix® Quadrivalent Lot # 72RF2 Expires 06/30/2025
Temp: 97.5



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