



WARHAWK
HEALTH SERVICES

Vaccine Consent and Administration Record

Name: Debra Tomlin DOB: 7-16-1957 Phone: 244-3250
Mailing Address: 801 Williamsburg Dr City: Pike Road ST: NC Zip: 36064
Insurance Company: BCBS Subscriber name: Debra Tomlin DOB: 7-16-57
Insurance Contract Number: _____ Group number: _____

Screening Questions:			
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)			
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 Tomlin Administration Date: 10/2/2020 Route: IM LD or RD Volume: 0.5cc
Administrator: [Signature] VIS Date 08/15/2019
Manufacturer: GSK Fluarix® Quadrivalent Lot # 9A235 Expires 06/30/2021

