AUM
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: _____
(First Name, Middle Initial, Last Name)

Date of Birth: _____ Social Security Number: _____

Phone #: _____ Email: _____

Patient Address: _____ _____ _____
(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: _____ Date Received: _____		
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.

_____ _____ _____
(Print Name) (Sign Name) (Date)

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

VACCINE	LOT #	EXPIRATION DATE	DOSE/ROUTE	SITE	DATE/TIME RECEIVED	Administered By:

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. *****