



**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: Jongheon Kim
(First Name, Middle Initial, Last Name)

Date of Birth: 10/18/1967 Social Security Number: 480 21 2928

Phone #: 860-834-1290 Email: JKim23@aum.edu

Patient Address: 8907 Thorneberry Ct. Montgomery 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>Pfizer</u> Date Received: <u>2/12/21</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.

Jongheon Kim [Signature] 3-5-2021
(Print Name) (Signature) (Date)