



## 2020-2021 COVID-19 Vaccine Consent

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

Name of Person Receiving Vaccine: Bongjae Lee  
(First Name, Middle Initial, Last Name)  
Date of Birth: Aug. 27, 1985 Social Security Number: 868-55-0914  
Phone #: 334-531-0345 Email: hnfa.bongjaelee@gmail.com  
Patient Address: 160 Stone Park Blvd pike Road AL 36064  
(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?                                     |     | <input checked="" type="checkbox"/> |
| 2.) Have you ever had a life-threatening allergic reaction to any vaccine?                                               |     | <input checked="" type="checkbox"/> |
| 3.) Do you have a bleeding disorder or are on a blood thinner?                                                           |     | <input checked="" type="checkbox"/> |
| 4.) Are you pregnant or planning to become pregnant? (Will need written approval from OB/GYN prior to receiving vaccine) |     | <input checked="" type="checkbox"/> |
| 5.) Do you currently have an acute illness and/or high fever?                                                            |     | <input checked="" type="checkbox"/> |
| 6.) Are you immunocompromised or on a medication that affects your immune system?                                        |     | <input checked="" type="checkbox"/> |
| 7.) Have you received another COVID-19 vaccine?                                                                          |     | <input checked="" type="checkbox"/> |
| If Yes, Vaccine Name: _____ Date Received: _____                                                                         |     |                                     |
| 8.) Have you tested positive for COVID-19 PCR or antibodies in the last ninety (90) days?                                |     | <input checked="" type="checkbox"/> |

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.

Bongjae Lee

(Print Name)

[Signature]

(Sign Name)

04.09.2021

(Date)

### Staff Use Only

| VACCINE | LOT #  | EXPIRATION DATE | DOSE/ROUTE | SITE | DATE/TIME RECEIVED | Administered By: |
|---------|--------|-----------------|------------|------|--------------------|------------------|
| Pfizer  | ER9137 | 7/21            | 0.3ml      | LT   | 4/9/21<br>2:03pm   | C. Stewart       |

Next Appointment Date/Time: 4/30 @ 2pm

\*\*\*If you present to the Emergency Department for any treatment, please inform the staff you have received the

COVID-19 vaccine. \*\*\*