Exhibit (D)

AirV&V Health Services Form

AIR V&V GUAM
VACCINATION + VACATION
USA

CONTACT INFORMATION

First Name: _____ Last Name:_____

Date of Birth:_____/_____/_____

Email:_____

Phone:_____

TRAVEL INFORMATION

Date of Arrival:_____/_____/_____ Country of Origin:_____

Hotel:_____ Room Number:_____

Estimated Date of Departure: ____/____/_____

PCR TEST INFORMATION

Preferred date of First PCR test : _____/_____/_____

Preferred date of second PCR test: _____/_____/_____

VACCINE INFORMATION

Select the Vaccine you would like:

Pfizer Moderna Jansen (Johnson and Johnson)

CONSENT

I have read the attached mRNA COVID-10 vaccine fact sheet. I understand the expected benefits and possible risks and side effects of the vaccines. I have voluntarily chosen to receive the vaccination and consent to the administration. I understand the possible risks to myself if I am not vaccinated. I will alert my provider of any medical conditions which m ay adversely affect my personal health or effectiveness of the vaccine. I have had the opportunity to have my questions answered by American Medical Center staff. I authorize American Medical Center staff to administer the mRNA COVID-19 vaccine to myself.

Printed Patient name:_____Patient Signature:_____

Date signed: ____/____/____