COVID-19 VACCINE CONSENT FROM

Name of Recipient:_____

Date of Birth:_____ Sex: Female Male Email:_____

Address:_____ Phone Number:_____

City:_____ State:_____ Zip:_____

I declare that I am 18 years of age or older, I further declare that I:

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from previous vaccinations or injectable medication.
2. Have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
3. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
4. Has not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 withing the past ninety (90) days.
5. Is no allergic to the following ingredients in the COVID-19 vaccine: mRNA, lipids((4-hydroxybutyl)azanediyl)bis(hexane-6, 1-diyl)bis(2-hexyldeconoate), 2[(polyethylene glycol)-2000]-N, N-ditetradecylacetylamide, 1, 2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate and sucrose.

I understand that if I have any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine. I further declare that if I or have any of the following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine:

1. Pregnant, attempting to become pregnant or breastfeeding.
2. Have a bleeding disorder or are on a blood thinner.
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer leukemia, ankylosing spondylitis or radiation treatment).

I agree to WAIT in the pharmacy for 15 minutes after receiving the vaccine.

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the injections site, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Razook's Pharmacy and its affiliates. The owners and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration for Razook's Drug giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless Razook's Drug, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers, and agents from an against any and all demands, damages, losses, cost, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. Razook's Drug makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness. I acknowledge receipt of Razook's Drug Notice of Privacy Practices.

Medicare Part B recipients: I understand Razook's drug will process Medicare part B claims on my behalf and accepts Medicare payment in full. I understand I must present my Medicare card prior to receiving the vaccine. I understand that if I assigned my Medicare benefits to the Medicare Advantage Plan (like HMO or PPO), I must receive my COVID-19 vaccine shot from my HMO/managed care provider or pay the Razook's Drug charge.

Private Insurance Participants: if I have private insurance, I understand that Razook's Drug will bill contracted insurance plans for the vaccine and or administrative costs for the vaccine. I also understand that my insurance company my not reimburse any of these expenses for which I will guarantee payment.

I have read, understand, and confirm I was given and completed accurately the following forms: Razook's Drug Patient Intake Form, Pre-Vaccination Checklist for COVID-19 Vaccines, Fact Sheet for Recipients and Caregivers, the vaccine information sheet (VID the V-Safe registration information and the Razook's Drug consent form.

I understand and agree to all the above and I hereby give my consent to the staff of Razook's Drug to give me a COVID-19 vaccine.

Signature of Patient/Parent:_____Date:_____

Vaccine Lot/ Exp Date	Route	Administered by:	Amount Paid	Method