Galen Pharmacy, LLC - COVID-19 Immunization Consent

Please carefully read this Consent to fully understand your rights

This Consent authorizes Galen Pharmacy, LLC and/or their affiliated entities to administer to me the COVID-19 vaccine.

I acknowledge that the COVID-19 vaccine should not be used/is contraidicated for:

- People with a history of severe allergic reaction to any ingredient of the vaccine or to a previous dose of any influenza vaccine

I understand and acknowledge that the COVID-19 vaccine is an experimental vaccine and that I have been provided access to the Emergency Use Authorization (EUA), which states the potential benefits and risks of receiving the COVID-19 vaccine. I am aware of the possible side effects of the COVID-19 vaccine, including, without limitation, chills, fatigue, low-grade fever, and pain at the injection site, and that there is no guarantee that the vaccine will be effective or that I will not experience adverse side effects from the vaccine. I have had an opportunity to ask questions regarding the COVID-19 vaccine, which were answered to my satisfaction.

I understand and acknowledge that the COVID-19 vaccine requires a second dose or booster shot subsequent to the initial administration of the vaccine and that receipt of the booster shot is required to increase the likelihood of effectiveness of the COVID-19 vaccine. I understand and acknowledge that I am responsible for obtaining the booster shot following my receipt of the initial COVID-19 vaccine and that the COVID-19 vaccine may not be effective if I do not receive the booster shot.

I understand and acknowledge that I am responsible for my own safety and actions upon my receipt of the COVID-19 vaccine and booster shot, and, if I experience any adverse side effects or other problems from the vaccine, I should contact my physician or seek emergency medical care. **I have been advised to report any severe side effects from this vaccine to (423) 618-9006**.

With full knowledge of the risks involved in receiving the COVID-19 vaccine, I release, waive, and discharge Galen Pharmacy LLC, and its Board of directors, officers, independent contractors, affiliates, employees, representatives, successors, and assigns, from any and all liabilities, claims, demands, actions, and/or causes of action of any nature whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death that I may sustain related to receiving the COVID-19 vaccine.

By signing below, I acknowledge that I have read the foregoing Consent and understand it contents; that I am competent and authroized to give consent; that I have been sufficiently informed of the benefits and risks involved with receiving the COVID-19 vaccine; and that I give my voluntary consent for vaccination by Galen Pharmacy, LLC and its staff, free from inducement or representation, as my own free act and deed with full intention to be bound by the same.

Signature (Patient or Authorized Representative) Date

Patient Name (Printed)	
Date of Birth	
Phone Number	
Street Address	
City/State/Zip Code	
Sex	
Race	
Hispanic or Latino (Y/N)	

Prescription ID Card	
RxBIN	
RxPCN	
RxGrp	
ID	
Name	

TO BE COMPLETED BY PERSON ADMINISTERING VACCINE

	Date Administered:	Body Site (L/R):
		Vaccinator Initials:
	Date Administered:	Body Site (L/R):
		Vaccinator Initials: