I acknowledge the following points for myself or the person for whom this appointment is being scheduled and I am legally able to make medical decisions:

Vaccine Acknowledgements

- I have been provided the Emergency Use Authorization (EAU) Fact Sheet for Recipients and Caregivers along with a completed Vaccination card and V-safe information.
- I have read the information provided and understand the information.
- I understand all benefits and risks of the vaccine(s) and accept the full responsibility for any reactions that I may have.
- I understand that I must stay in the area for 15 to 30 minutes after I receive the vaccine so that I can be monitored for any potential adverse reactions.
- I understand that if I experience any side effects after leaving the pharmacy, I should contact the pharmacy or my doctor. If I feel that my life is in danger, I should immediately call 911.
- I understand that I may receive a vaccine that requires a second dose at a specific time frame and that it is my responsibility to keep any future appointments for follow-up doses or care.
- Georgia only: I verify that a case history was taken by the pharmacist and I was asked if I had a physical exam in the past 12 months and that no condition that would prevent me from receiving the vaccine was identified.
- Consent for Pfizer-BioNTech vaccination of minor: If scheduling an appointment for a minor (12-17 years of age) to be vaccinated with Pfizer-BioNTech vaccine:
    - I understand that information available from the Centers for Disease Control and Prevention ("CDC"), including the "Fact Sheet for Recipients and Caregivers," includes more detailed information about the potential risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine.
    - I have the legal authority to consent to have the child for whom an appointment is being scheduled vaccinated with the Pfizer-BioNTech COVID-19 Vaccine.
    - If permitted under the state law, I consent to the child receiving the Pfizer-BioNTech COVID-19 Vaccine whether or not I am present at the vaccination appointment.
    - I understand that all immunizations will be reported to the state Immunization Information System (IIS) and the CDC.

Records Acknowledgement

- I understand that the pharmacy may be required to or may voluntarily disclose my health information to a physician responsible for the protocol of people vaccinated by the pharmacy (if applicable), my personal primary care provider (if I have one), my insurance plan or other payer, health systems and hospitals, and/or state or federal registries. These disclosures would be limited to treatment, payment, required government reporting or other health care operations.
- I have received a copy of the pharmacy's notice of privacy practices.

Payment Authorization

I do hereby authorize the pharmacy to release information and request payment for administration of the vaccine(s). I certify that the information I have given for payments from Medicare or Medicaid is correct. I authorize the release of all records needed to complete the payment request. I request that payment of authorized benefits be made on my behalf.