Please read the adverse reactions associated with the administration of vaccines. The vaccine you are receiving may have been authorized by the FDA under Emergency Use Authorization (EUA). Vaccines authorized under EUA have been rigorously assessed for efficacy and safety. A copy of the vaccine manufacturer's drug information sheet is available on request. Furthermore, I have had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below for whom I am the legal guardian. My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Costco, and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither Costco nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible or any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccines described above. Costco will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and your Ward’s personal health information. I acknowledge that I have received a copy of the Notice of Privacy Practices.

SIGNATURE/LEGAL GUARDIAN

PRINT NAME

ADMINISTRATIVE RECORD For pharmacy use only

DATE OF VACCINATION/DATE VIS GIVEN PHARMACY NAME PHARMACY ADDRESS

PHARMACIST/PRESKRIBER SIGNATURE - SUBSTITUTION PERMITTED


VACCINE: SITE OF INJ: LOT NO: EXP DATE: RT OF ADMIN: VIS VERSION: DOSAGE:

Please provide a copy of this form to your physician and/or healthcare provider for your permanent medical records.

WHITE - Administrative Copy YELLOW - Patient Copy

PHARMWIDE 3130182-1027